Calendar No. 426

97TH CONGRESS
2d Session
SENATE
REPORT
No. 97-325

# COMMUNITY HOME HEALTH SERVICES ACT OF 1981

# REPORT

OF THE

## COMMITTEE ON LABOR AND HUMAN RESOURCES

## UNITED STATES SENATE

TO ACCOMPANY

S. 234

together with

ADDITIONAL VIEWS

MARCH 23 (legislative day, FEBRUARY 22), 1982.—Ordered to be printed

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97TH CONGRESS 2d Session } SENATE { REPORT No. 97-325

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# COMMUNITY HOME HEALTH SERVICES ACT OF 1981

MARCH 23 (legislative day, FEBRUARY 22), 1982.—Ordered to be printed

Mr. HATCH, from the Committee on Labor and Human Resources, submitted the following

## REPORT

together with

## ADDITIONAL VIEWS

[To accompany S. 234]

The Committee on Labor and Human Resources, to which was referred the bill (S. 234), to amend the Public Health Service Act to encourage the establishment of home health programs and to amend the Social Security Act to provide expanded coverage of home health services under the medicare and medicaid programs, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill as amended do pass.

### SUMMARY OF LEGISLATION

As approved by Committee, S. 234:

1. Amends the Public Health Service Act to provide grants to nonprofit entities and loans to proprietary agencies for: the establishment and initial operation of home health programs; and training programs for professional and paraprofessional personnel to provide home health services.

2. Amends Section 1814, 1835, and 1833 of the Social Security Act to provide that the need for homemaker/home health aide service shall be a qualifying service under Medicare and that in the case of individuals who qualify solely by virtue of the need for homemaker/home health aide services shall be reimbursed at 50 percent.

3. Amends Section 1861 of the Social Security Act, the definition of home health services, to include treatment of chronic obstructive pulmonary disease and respiratory therapy; to require, to the extent permitted by regulations, services of a part-time or intermittent

homemaker-home health aide who has successfully completed a training program as designated in this Act; and allows the Secretary to waive the requirement that home health services must be provided by a home health agency when the Secretary determines that such entity is in compliance with regulations set forth to assure quality, effectiveness and efficiency of such services; and amending (v)(1)(L)(ii) of that same section to include "Such limitation shall not vary between hospital-based home health agencies and freestanding home health agencies."

4. Amends Section 1902 of the Social Security Act to require that any homemaker/home-health aide services paid for under Medicaid programs must be provided by an aide meeting the requirements of Section 1861 (m)(4)(A) of this Act.

5. Requires the Secretary to compile and analyze alternative reimbursement methodologies for home health services, to determine with reference to these new services which he determines to be most cost-effective and carry out demonstration projects to test alternative reimbursement methods to determine the most cost-effective and efficient way of providing home health services; and to undertake a thorough investigation of methods available in stemming fraud and abuse and the extent to which they are applied.

6. Amends the Internal Revenue Code of 1954 to include a new section 44H., allowing a credit for expenses paid in the support of certain qualified dependents living at home instead of an institution of $500 for taxpayer's with an adjusted gross income of $30,000 or less.

## HISTORY AND HEARINGS

S. 234, a bill amending Section 339 of the Public Health Service Act and Sections 1814, 1833, 1835, 1861 and 1902 of the Social Security Act and amending the Internal Revenue Code to include a new section, 44H and for other purposes, was introduced on January 22, 1981, by Senator Hatch and was referred to the Committee on Labor and Human Resources. Public hearings on S. 234 were held on March 4, 1981, and November 10, 1981, by the Committee on Labor and Human Resources.

The following witnesses appeared on March 4th: Dr. Phillip W. Brickner, Director, Department of Community Medicine, St. Vincent's Hospital and Medical Center; Anthony J. Lechlich, M.D., Assistant Professor of Clinical Medicine, New York Medical College; Sam P. Giordano, Executive Director, American Association for Respiratory Therapy; Alfred Abunza, M.D., Chief of Medicine and Chairman, Respiratory Therapy Department, St. Mark's Hospital, Salt Lake City, Utah; Glen Gee, Director of Respiratory Care Services, Loma Linda University Medical Center, Loma Linda, California; Sue Roselle Worstell, Director, Allied Health Services, South Hills Health System Home Health Agency, Pittsburgh, Pennsylvania; Bill Halamandaris, Executive Director, National Association of Home Health Agencies; Ronald B. Reck, President, American Federation of Home Health Agencies and Administrator, Home Health Services of Allegheny County, Pittsburgh, Pennsylvania; Teodosia Kelsey, American Occupational Therapy Association, Inc., Zoe Dunphy, Member, Board of Directors, the National Retired Teachers Association and the American Association of Retired Persons; Ronald E. Rosenberg, Chairman of the Board, Home Health Services and Staffing Association.

The following witnesses appeared on November 10th: Miss Helen Hayes; Eleanor Chelimsky, Director, Institute for Program Analysis; Dr. Phillip W. Brickner and Dr. Anthony Lechlich (affiliations listed above); Mark Blitz, Assistant Director, Policy Planning, ACTION Agency; Elmer Cerin, Vice President, Amyotrophic Lateral Sclerosis Society, Washington, D.C.; W. Winslow Turner, Esq., Coordinator of the Government Relations Committee of the National Board of the National Multiple Sclerosis Society; Marilyn Schaengold, Holy Cross Hospital, Maryland; Donald W. Wortley, R.P.T., Council of Home Health Agencies, Community Health Services of the National League for Nursing, Salt Lake City, Utah; Ronald E. Rosenberg, Ronald B. Beck (see affiliation above); Emily Layzer, Director of Social Policy and Legislation, National Homecaring Council, New York City; Mary C. Suther, Chairperson, Governmental Affairs Committee, National Association of Home Health Agencies; William J. Simione, Jr., C.P.A.—Simione and Simione, Public Accounts, Inc., Hamden, Connecticut.

Testimony for the record was also received from the following organizations and individuals: (March 4th) Honorable Charles E. Grassley, U.S. Senator, Iowa: American Hospital Association; The Proprietary Association, The National HomeCaring Council, National League for Nursing (November 10th); Thomas I. Harnish, President and Chief Operating Officer, Respicare, Inc., Columbus, Ohio; The Catholic Health Association of the United States; The American Hospital Association; The American Occupational Therapy Association, Inc.; American Association of Homes for the Aging; Fairfield County Respiratory Associates, John M. Zavatsky, Jr., President, The Elvirita Lewis Foundation for Geriatric Health and Nutrition; Steven W. Brummel, Executive Director; Home Health Agency Assembly of New Jersey, Inc.; American Association for Respiratory Therapy; Travenol Laboratories, Inc.; Northwestern University, Center for Health Services and Policy Research; Honorable Tarky Lombardi, Jr., New York State Senate.

On December 15, 1981, in open executive session of the Committee on Labor and Human Resources, the Committee considered and adopted, with amendments, the "Community Home Health Services Act of 1981" after receipt of comments from many individuals, organizations and associations and the study of comments from the Government Accounting Office and others.

## TEXT OF S. 234 AS REPORTED

The text of the committee substitute amendment is as follows:
Strike out all after the enacting clause as follows:

### [SHORT TITLE

[SECTION 1. This Act may be cited as the "Community Home Health Services Act of 1981".

### [PURPOSE

[SEC. 2. It is the purpose of this Act to encourage the establishment of home health programs, to expand the coverage of home health services under medicare and medicaid in general, and to expand such coverage of community home health services provided by hospitals.

### [GRANTS AND LOANS FOR HOME PROGRAMS

[SEC. 3. (a)(1) Section 330(a)(1) of the Public Health Service Act is amended—

[(A) by striking out "purpose of demonstrating" and inserting in lieu thereof "purpose of encouraging";

[(B) by striking out "home health agencies (as defined in section 1861(o) of the Social Security Act) and inserting in lieu thereof "home health programs";

[(C) by inserting "and loans to proprietary entities" after "private entities';' and

[(D) by striking out "operating such agencies and expanding the services available" and all that follows and inserting in lieu thereof the following: "operating such programs. Such grants may include funds to provide training to such programs' professional and paraprofessional personnel to provide home health services (as defined in section 1861(m) of the Social Security Act). Priority in the award of grants and loans shall be given to areas which do not have home health services, and special consideration in the award of grants and loans shall be given to areas with inadequate means of transportation.".

[(2) Section 339(a)(2) of such Act is amended by inserting "and loans" after "grants".

[(3) Section 339(a)(3) of such Act is amended by inserting "and loans" after "grants".

[(4) Section 339(a)(4) of such Act is amended by inserting "and loans" after "grants".

[(5) Section 339(a)(5) of such Act is amended by striking out "and" after "1980," and by inserting before the period at the end thereof the following: ", and $5,000,000 for each of the three succeeding fiscal years".

[(6) Section 339(a) of such Act is amended by adding at the end thereof the following new paragraph:

["(6) There are authorized to be appropriated for loans under this section $3,000,000 for the fiscal year ending September 30, 1982, and each of the two succeeding fiscal years.".

[(b) Section 339(b)(4) of such Act is amended by striking out "and" after "1980," and by inserting before the period at the end thereof the following: ", and $2,000,000 for the fiscal year ending September 30, 1982".

[(c) Section 339 of such Act is amended by adding at the end thereof the following new subsection:

["(c) The Secretary shall report to the Senate Committee on Labor and Human Resources and the House Committee on Energy and Commerce on or before December 31, 1981, with respect to—

["(1) the impact of training grants made under this section prior to September 30, 1981;

["(2) the need to continue training grants under this section;

["(3) the extent to which uniform standards have been applied to the training of home health personnel; and

["(4) the extent to which training costs are, or could be made, reimbursable under titles XVIII and XIX of the Social Security Act.".

### [MEDICARE AND MEDICAID PROVISIONS

[SEC. 4. (a) Section 1861(m) of the Social Security Act is amended—

[(1) by striking out "by a home health agency or by others under arrangements made with them by such agency" and inserting in lieu thereof "by a nonprofit hospital or a home health agency, or by others under arrangements made with them by such hospital or agency";

[(2) in paragraph (1), by striking out "nursing care" and inserting in lieu thereof "nursing services for chronic or acute care";

[(3) by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), and inserting after paragraph (5) the following new paragraph:

["(6) the services of a homemaker when medically required;";

[(4) in paragraph (7) as so redesignated, by inserting "a nonprofit hospital or" after "in the case of";

[(5) in paragraph (8) as so redesignated—

[(A) by inserting "the nonprofit hospital or" after "arrangements made by"; and

[(B) in subparagraph (B), by striking out "but not including transportation of the individual in connection with any such item or service" and inserting in lieu thereof "including transportation, whether by ambulance or other means, in connection with any such item or service"; and

[(6) by adding at the end thereof the following:

["Notwithstanding any other provisions of this title, the term 'home health services' includes (without regard to any of the preceding provisions of this subsection) any professional health services provided in an individual's home by a nonprofit hospital, or by members of its staff acting as such (including its physicians, nurses, social workers, therapists, technicians, home health aides, homemakers, housekeepers, dietitians, and other personnel) as an alternative to institutional care, if such services do not qualify for payment (as outpatient hospital services or otherwise) under the other provisions of this title; excluding, however, any item or service (other than the service of home health aides, homemakers, or housekeepers) if it would not be included under subsection (b) if furnished to an inpatient of a hospital.".

[(b) Section 1902(a)(13)(A) of such Act is amended by striking out "and" at the end of clause (i) and by adding after clause (ii) the following:

[(iii) for the inclusion as a 'home health service' under the plan of any item or service which is included as a 'home health service' under title XVIII of this Act, and".

[(c) The amendments made by this section shall become effective ninety days after the date of the enactment of this Act and shall be effective only with respect to items and services furnished on or after such effective date.]

and insert in lieu thereof the following:

That this Act may be cited as the "Community Home Health Services Act of 1981".

### PURPOSE

SEC. 2. It is the purpose of this Act to encourage the establishment of home health programs, to expand the coverage of home health services for the elderly and disabled under medicare and medicaid, and to encourage individuals to provide care for certain qualified disabled dependents in the home of the individual.

### GRANTS AND CONTRACTS FOR HOME HEALTH SERVICES AND TRAINING

SEC. 3. Part D of title III of the Public Health Service Act is amended by inserting after subpart II the following new subpart:

### "SUBPART III—HOME HEALTH SERVICES

### "HOME HEALTH SERVICES

"SEC. 339. (a)(1) For the purpose of encouraging the establishment and initial operation of home health programs to provide home health services (as defined in section 1861(m) of the Social Security Act) in areas in which such services are not otherwise available, the Secretary may, in accordance with the provisions of this section, make grants to public and nonprofit private entities and loans to proprietary entities to meet the initial costs of establishing and operating such home health programs. Such grants and loans may include funds to provide training to professional and paraprofessional personnel to provide home health services (as defined in section 1861(m) of the Social Security Act). The Secretary shall make grants and loans to entities for home health programs only in those areas which do not have adequate home health services, and shall give special consideration to areas with inadequate means of transportation to obtain necessary health services.

"(2) In making grants and loans under this subsection, the Secretary shall—

"(A) consider the relative needs of the several States for home health services; and

"(B) give preference to areas in which a high percentage of the population proposed to be served is composed of individuals who are elderly, medically indigent, or disabled.

"(3) (A) No loan may be made to a proprietary entity under this section unless the application of such entity for such loan contains assurances satisfactory to the Secretary that—

"(i) at the time the application is made the entity is fiscally sound;

"(ii) the entity is unable to secure a loan for the project for which the application is submitted from non-Federal lenders at the rate of interest prevailing in the area in which the entity is located; and

"(iii) during the period of the loan, such entity will remain fiscally sound.

"(B) Loans under this section shall be made at an interest rate comparable to the rate of interest prevailing on such date with respect to the marketable obligations of the United States of comparable maturities, adjusted to provide for administrative costs.

"(4) Applications for grants and loans under this subsection shall be in such form and contain such information as the Secretary shall prescribe.

"(5) Payments under grants and loans under this subsection may be made in advance on the basis of estimates or by way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of such grants and loans.

"(6) There are authorized to be appropriated for grants and loans under this subsection $5,000,000 for each of the fiscal years ending September 30, 1983, and September 30, 1984.

"(b) (1) The Secretary may make grants to and enter into contracts with public and private entities to assist them in developing appropriate training programs for professional and paraprofessional personnel to provide home health services (as defined in section 1861(m) of the Social Security Act).

"(2) In making grants and entering into contracts under this subsection, special consideration shall be given to entities which establish or will establish programs to provide training for persons fifty years of age and older who wish to become homemaker home health aides.

"(3) Applications for grants and contracts under this subsection shall be in such form and contain such information as the Secretary shall prescribe.

"(4) Payments under grants and contracts under this subsection may be made in advance on the basis of estimates or by way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of such grants and contracts.

"(5) There are authorized to be appropriated for grants and contracts under this subsection $2,000,000 for each of the fiscal years ending September 30, 1983, and September 30, 1984.

"(C) The Secretary shall report to the Committee on Labor and Human Resources of the Senate and the Committee on Energy and Commerce of the House of Representatives on or before January 1, 1984, with respect to—

"(1) the impact of grants made and contracts entered into under subsections (a) and (b) (as such subsections were in effect prior to October 1, 1981);

"(2) the need to continue grants and loans under subsections (a) and (b) (as such subsections are in effect on the day after the date of enactment of the Community Home Health Services Act of 1981);

"(3) the extent to which standards have been applied to the training of personnel who provide home health services;

"(4) the extent to which training costs for personnel who provide home health services are, or could be made, reimbursable under titles XVIII and XIX of the Social Security Act; and

"(5) the efforts and progress of the Department in stemming any fraud and abuse with respect to home health services provided under this section and under titles XVIII and XIX of the Social Security Act."

## MEDICARE AND MEDICAID PROVISIONS

SEC. 4. (a) (1) Section 1814(a) (2) (D) of the Social Security Act is amended to read as follows:

"(D) in the case of home health services—

"(i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m) (7));

"(ii) such services are or were required because the individual needs or needed—

"(I) skilled nursing care on an intermittent basis,

"(II) physical or speech therapy, or

"(III) homemaker-home health aide services on an intermittent basis (which are not otherwise available through family or community resources on a more cost-effective basis), or occupational or respiratory therapy; but only if such individual would require institutionalization in the absence of such homemaker-home health aide services, or occupational or respiratory therapy,

"(iii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and

"(iv) such services are or were furnished while the individual was under the care of a physician; or".

(2) Section 1835(a)(2)(A) of such Act is amended to read as follows:

"(A) in the case of home health services—

"(i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7));

"(ii) such services are or were required because the individual needs needed—

"(I) skilled nursing care on an intermittent basis,

"(II) physical or speech therapy, or

"(III) homemaker-home health aide services on an intermittent basis (which are not otherwise available through family or community resources on a more cost-effective basis), or occupational or respiratory therapy; but only if such individual would require institutionalization in the absence of such homemaker-home health aide services, or occupational or respiratory therapy;

"(iii) a plan furnishing such services to such individual has been established and is periodically reviewed by a physician; and

"(iv) such services are or were furnished while the individual was under the care of a physician;".

(b) Section 1861(m) of such Act is amended—

(1) in paragraph (2), by adding after "speech therapy" the following: ", or, with respect to services related to the treatment of chronic obstructive pulmonary disease, respiratory therapy";

(2) by amending paragraph (4) to read as follows:

"(4) to the extent permitted by regulations, services of a part-time or intermittent homemaker-home health aide—

"(A) who—

"(i) has successfully completed a training program which extends for at least 40 hours, and consists of classroom instruction and at least 20 hours (in the aggregate) of supervised clinical instruction, and which is directed toward preparing students to deliver home health services; or

"(ii) has demonstrated, pursuant to regulations promulgated by the Secretary, an equivalent amount of training by work experience, or through testing, licensure, or other means;

"(B) which are carried out under appropriate professional supervision and are designed to maintain or enhance the personal care of an individual in his home (but not including any structural changes to the home) in a manner which promotes the functional independence of the individual; and

"(C) which include—

"(i) personal care services designed to assist such individual in the activities of daily living such as bathing, exercising, personal grooming, and getting in and out of bed; and

"(ii) household care services such as maintaining a safe living environment, light housekeeping, and ensuring good nutrition (including the purchase and preparation of food);";

(3) in paragraph (7)(B), by striking out "but not including transportation of the individual in connection with any such item or service" and inserting in lieu thereof "including transportation of the individual in connection with any such item or service if such item or service cannot be pro-

vided within the home in a more cost-effective manner (as determined by the Secretary in regulations)"; and

(4) by adding at the end thereof the following unnumbered paragraph:

"The Secretary may by regulation waive the requirement that home health services must be provided by a home health agency when such services can be provided by an entity which demonstrates that it can substantially comply with the provisions of subsection (o), but only if the Secretary determines that such entity provides such services in a manner which assures the quality of, and the effective and efficient delivery of, such services.".

(c) (1) Section 1814(b) of such Act is amended—

(A) by striking out "except as provided in paragraph (3)" in paragraph (1) and inserting in lieu thereof "except as provided in paragraphs (3) and (4)";

(B) by striking out "or" at the end of paragraph (2);

(C) by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; or"; and

(D) by inserting after paragraph (3) and before the last sentence of subsection (b) the following new paragraph:

"(4) 50 percent of the amount which would otherwise be paid under this part in the case of payment for the services of a homemaker-home health aide which constitute home health services provided to an individual who meets the requirements of subsection (a)(2(D) only by reason of his need for the services of a homemaker-home health aide, occupational therapy, or respiratory therapy.".

(2) Section 1833(a)(2) of such Act is amended—

(A) by inserting ", except as otherwise provided in subparagraph (D) of this paragraph, " after "home health services" in subparagraph (A);

(B) by striking out "and" at the end of subparagraph (B);

(C) by adding "and" at the end of subparagraph (C); and

(D) by adding after subparagraph (C) the following new subparagraph:

"(D) 50 percent of the amount which would otherwise be paid under this part in the case of the services of a homemaker-home health aide which constitute home health services provided to an individual who meets the requirements of section 1835(a)(2)(A) only by reason of his need for the services of a homemaker-home health aide, occupational therapy, or respiratory therapy.".

(d) Section 1861(v)(1)(L)(ii) of such Act is amended by inserting after the first sentence the following new sentence: "Such limitation shall not vary between hospital-based home health agencies and freestanding home health agencies.".

(e) Section 1902(a)(9) of such Act is amended—

(1) by striking out "and" at the end of subparagraph (B);

(2) by striking out the semicolon at the end of subparagraph (C) and inserting in lieu thereof ", and"; and

(3) by adding at the end thereof the following:

"(D) that any homemaker-home health aide services paid for under the plan must be provided by a homemaker-home health aide who meets the requirements of section 1861(m)(4)(A) of this Act;".

(f) The Secretary of Health and Human Services shall compile and analyze the results of significant studies carried out by any public or private entity, group, or individual, relating to current and alternative reimbursement methodologies for home health services. The Secretary shall make recommendations with respect to such reimbursement methodologies as they might be applied in health care programs funded in whole or in part by Federal funds, and report such recommendations to the Congress within one hundred and eighty days after the date of the enactment of this Act.

(g) Within one hundred and eighty days after the date of the enactment of this Act the Secretary of Health and Human Services shall implement, within the scope of his authority under section 1861(v) of the Social Security Act, and with respect to the new services provided under this Act, those reimbursement methodologies which he determines to be the most cost effective.

(h) The Secretary of Health and Human Services shall develop and carry out demonstration projects commencing no later than January 1, 1983, to test alternative reimbursement methodologies for home health agencies in order to determine the most cost-effective and efficient way of providing home health services under titles XVIII and XIX of the Social Security Act. Reimbursement methodologies to be tested by the Secretary may include but not be limited to fee schedules, prospective reimbursement, and capitation payments. The Secretary shall report to Congress his findings with regard to these demonstrations no later than January 1, 1984.

(i) The Secretary of Health and Human Services shall undertake a thorough investigation of—

(1) the methods available to stem fraud and abuse in the medicare and medicaid home health programs under titles XVIII and XIX of the Social Security Act; and

(2) the extent to which such methods are applied in stemming such fraud and abuse.

The Secretary shall report the results of the investigation to the Congress within eighteen months after the date of the enactment of this Act.

(j) The amendments made by this section shall become effective ninety days after the date of the enactment of this Act and shall be effective only with respect to items and services furnished on or after such effective date.

### REFUNDABLE INCOME TAX CREDIT

Sec. 5. (a) Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1954 (relating to credits allowable) is amended by inserting after section 44G the following new section:

### "SEC. 44H. HOUSEHOLDS WITH CERTAIN DISABLED DEPENDENTS.

"(a) In General.—In the case of an eligible individual, there shall be allowed a credit against the tax imposed by this chapter for the taxable year an amount equal to 50 percent of the excess, if any, of—

"(1) the expenses paid by such eligible individual in supporting any qualified dependent of such eligible individual during the calendar year ending with or within such taxable year, over

"(2) the amount of any exemption allowed such eligible individual under section 151 with respect to such qualified dependent for such taxable year.

"(b) Limitation.—The amount of credit allowable to any taxpayer under subsection (a) for any taxable year shall not exceed an amount equal to—

"(1) $500, reduced (but not below zero) by

"(2) $50 for each $1,000, or fraction thereof, of that portion of such taxpayer's adjusted gross income for such taxable year which is in excess of $30,000.

"(c) Definitions; Special Rules.—For purposes of this section—

"(1) Eligible individual.—The term 'eligible individual' means an individual who, for the calendar year ending with or within the taxable year, maintains as his home a household of which a qualified dependent of such individual for such calendar year is a member.

"(2) Qualified dependent.—The term 'qualified dependent' means, with respect to an eligible individual for the calendar year, any individual—

"(A) whose place of abode for at least 270 days of such calendar year is the home of such eligible individual,

"(B) who is a dependent of such eligible individual (within the meaning of section 152) for such calendar year,

"(C) who, under regulations prescribed by the Secretary after consultation with the Secretary of Health and Human Services, is determined to be afflicted by a medically determinable physical or mental impairment which can be expected to result in death or to be of a long-continued and indefinite duration, and

"(D) who would require institutionalization if adequate care at the home of such eligible individual was unavailable.

"(3) Maintenance of a household.—

"(A) In general.—An individual shall be treated as maintaining a household for a calendar year only if more than 50 percent of the cost of maintaining such household for such calendar year is furnished by such individual.

"(B) Multiple support agreements.—For purposes of subparagraph (A), any support of a qualified individual treated as received from an individual under section 152(c) for such calendar year shall be treated as a cost of maintaining such household furnished by such individual for such calendar year.".

(b)(1) Subsection (b) of section 6401 of such Code (relating to excessive credits treated as overpayments) is amended—

(A) by striking out "and 39" and inserting in lieu thereof ", 39",

(B) by striking out "and 43 (relating to earned income credit)" and inserting in lieu thereof "43 (relating to earned income credit), and 44H (relating to households with certain disabled dependent)", and

(C) by striking out "39 and 43" and inserting in lieu thereof "39, 43, and 44H".

(2) Paragraph (2) of section 55(b) of such Code (defining regular tax) is amended by striking out "and 43" and inserting in lieu thereof ", 43, and 44H".

(3) Sections 44C(b)(5), 44D(b)(5), 44E(e)(1), and 56(c) of such Code are each amended by striking out "and 43" and inserting in lieu thereof "43, and 44H".

(c) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 44G the following new item:

"Sec. 44H. Households with certain disabled dependents.".

(d) The amendments made by this section shall apply to taxable years beginning after December 31, 1982, and before January 1, 1985.

(e)(1) The Secretary of the Treasury shall prepare a report which estimates—

(A) the number of individuals who were allowed the credit under section 44H of the Internal Revenue Code of 1954 with respect to taxable years beginning in 1983, and

(B) the total effect on the revenues of the United States of allowing such credits.

(2) The report required under paragraph (1) shall be submitted to the Congress no later than by September 30, 1984.

Amend the title so as to read:

A bill to amend the Public Health Service Act to encourage the establishment of home health programs, to amend the Social Security Act to provide expanded coverage of home health services and to provide coverage of home health services under the medicare and medicaid programs for the elderly and disabled, and to amend the Internal Revenue Code of 1954 to provide a credit for households with certain qualified disabled dependents.

## BACKGROUND

### THE NEED FOR EXPANDED HOME HEALTH SERVICES

Medicare and Medicaid (and to a lesser extent title XX of the Social Security Act) are the principal Federal programs that finance home health care services. Medicare, authorized under title XVIII of the Social Security Act, is a Federal health insurance program for most persons aged 65 and over, persons under 65 entitled to Federal disability benefits, and certain individuals with end-stage renal disease. Home health services covered under Medicare include the following:

Part-time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse;

Physical, occupational, or speech therapy;

Medical social services provided under the direction of a physician;

Medical supplies and equipment (other than drugs and medicines);

Medical services provided by an intern or resident enrolled in a teaching program in a hospital affiliated or under contract with a home health agency; and

Part-time or intermittent services provided by a home health side, as permitted by regalations.

To qualify for home health services, the Medicare beneficiary must be confined to his/her home and under the care of a physician. In addition, the person must be in need of part-time or intermittent skilled nursing care or physical or speech therapy. Services must be provided by a home health agency certified to participate under Medicare, according to a plan of treatment prescribed and reviewed by a physician. There is no numerical limit on home health visits covered under Medicare. Nor is the patient subject to any cost-sharing, e.g. deductibles or coinsurance, for covered home health services.

Medicaid, authorized under title XIX of the Social Security Act, is a Federal-State matching program providing medical assistance for certain low-income persons. Each State administers its own program and, subject to Federal guidelines, determines eligibility and scope of benefits, as well as the reimbursement rate for services provided to Medicaid recipients. Medicaid's definition of home health services (found in regulations rather than statute) is similar to Medicare's, but the scope and amount of services provided can vary from State to State.

All States must provide home health services for Medicaid recipients over 21 years of age who are categorically needy. In addition, a State must provide home health services to categorically needy recipients under 21 years of age and medically needy recipients if such individuals are eligible to receive skilled nursing services under a State's medical assistance plan. However, States are free to impose restrictions such as visit and reimbursement limits, patient cost-sharing, or requirements for prior authorization of services. States can also require that a patient be homebound or in need of skilled care in order to receive benefits, but such requirements are not federally mandated, as under the Medicare program.

Many States currently place limits on the number of home health visits covered under their Medicaid plans; in addition, many require prior authorization as a condition to receipt of service, or limit the type of service covered.

Even though its share of total expenditures remains small, home health care has in recent years become one of the fastest growing components of the Medicare and Medicaid budget and accounts for about 2.2 percent of total Medicare expenditures. The number of Medicare home health visits has also grown—from 8.1 million in 1974 to 17.3 million in 1978.

Although it accounts for less than half the amount Medicare spends on home health, the Medicaid program is also experiencing an increase in the amount of resources devoted to home health care. In 1972, home health visits were provided to about 113,000 persons under Medicaid. For 1980 it is estimated that more than 393,000 persons will be recipients of home health benefits under Medicaid. Medicaid expenditures for home health services are expected to reach $331.7 million in FY 1980, representing about 1.42 percent of total Medicaid expenditures. In only 8 States do home health benefits currently represent more than 1 percent of total Medicaid outlays. However, one State (New York) alone accounts for between 75 and 80 percent of total Medicaid spending nationwide on home health services.

Despite the growth in the home health care expenditures under public programs, there still appears to be an unmet need for home care services. Measuring the actual extent of such need, however, has proven to be difficult. While numerous studies have examined this issue, the resulting projections of need have generally been expressed in fairly broad terms. For example, in a 1977 report, the Congressional Budget Office (CBO) compared the potential need and the available supply of home health care and found that 1.7 to 2.7 million people were in potential need of expanded home services, but only 300,000 to 500,000 were receiving them. A forthcoming GAO study, although not projectable to the total elderly population, indicates that between 10 and 22 percent of the elderly in some areas or cities are not receiving all the homemaker/chore and personal care services they need.

Attempts have also been made to examine and need for home care by studying the existing institutionalized population to determine if nursing home patients, for example, could be appropriately cared for in the community. In its 1977 report, CBO found that between 20 and 40 percent of all nursing home patients were inappropriately placed and could be cared for in less intensive settings, if adequate community care were available.

Some feel that further evidence of the potential need for home care can be found in the number of elderly residing unnecessarily in acute care hospitals. For example, it has been estimated that nationally 17,783 people or 6.9 percent of the Medicare and Medicaid patients in acute care hospitals surveyed were awaiting placement elsewhere. Some of these patients were felt to be potential candidates for home care if appropriate services were made available.

Annual surveys of New York hospitals indicate that the problem of hospital backup is severe and becoming worse. In 1979 there were 3,961 Medicare/Medicaid patients awaiting alternative placement; in 1980, there were 4,424. The average wait for these patients increased from 53 days in 1979 to over 74 days in 1980, a 40 percent increase in one year.

Hospital backup and inappropriate nursing home placement add unnecessary costs to an already expensive public investment in long term care. For nursing home care alone, the public share of the bill in 1980 reached $11.8 billion (with an additional $7.7 billion in nursing home care financed through private sources, overall expenditures for nursing home care have experienced annual increases averaging 16.6 percent since 1965.) These expenditures (from both public and private sources) are expected to reach $81.9 billion in 1990 (compared to $20.7 billion in 1980). Among the factors cited as contributing to this growth (in addition to inflation) are increases in life expectancy of the aged, increases in third-party payments for nursing home care and changing social patterns of family responsibility for the elderly.

Unless viable community-based alternatives to nursing home care are found which will prevent the needless institutionalization of large numbers of the elderly, we can only expect that the numbers of persons in nursing homes will grow as the elderly population expands disproportionally to the rest of the population. Today about 11 percent of the nation's population is over age 65. By the year 2030, the 55 million elderly projected for that time will comprise 22 percent of the total

U.S. population. Among the elderly, the proportion of those age 75 plus will increase even faster than those ages 65–74. Today 38 percent of those age 65 plus are also over age 75; more than 9 percent are age 85 plus. By the year 2030, the age 75 plus group is expected to constitute 45 percent and those 85 plus will represent 12 percent of those over age 65.

Roughly 5 percent of the total U.S. population over age 65 are currently residents of nursing homes. But the proportion of those 75 and older in nursing homes is much greater—22 percent of those over age 85 are in nursing homes. Assuming current utilization rates, estimates show that the number of nursing home residents (currently about 1.3 million) will increase by 54 percent over the next 20 years and by 132 percent—to a level of almost 3 million—by the year 2030.

These population shifts will have dramatic implications for future public policy in many areas. One of the most pressing areas will be the need for long term care and how best to meet the needs and desires of the elderly and chronically ill requiring such services. A recent report from the Health Care Financing Administration has noted, "as the population ages, the pressures for public involvement are likely to intensify."

Yet the government's ability to raise the revenues necessary to provide such care is not unlimited. To avoid the inevitable prospect of uncontrollable increases in public costs for long term care in nursing homes, we must consider alternatives which will encourage and assist the elderly who are infirm or chronically ill to receive health care at home rather than in expensive institutions. We must examine the incentives built into current public programs which encourage institutional care rather than community-based alternatives. We must devise new ways to encourage those families who are able to do so to care for their elderly parents at home within the supportive family setting.

It is the perception of this committee that increased utilization of home health care should result in long-term Federal cost savings through decreased nursing home and hospital admissions and shorter lengths of stay, as well as by increasing family support for the elderly. Of equal importance is the knowledge that increased availability of home health care will enable many elderly and chronically ill persons to maintain their independence and community ties and to lead lives of greater personal dignity and satisfaction.

Currently, the Medicare and Medicaid programs contain various incentives which tend to favor care for the elderly and chronically ill in institutional settings rather than the community. For example, Medicare's coverage focuses on acute care services of a relatively short-term nature. While there is no limit on the number of covered home health visits, such visits are restricted to those persons who are homebound and in need of skilled care, preconditions which generally exclude large numbers of chronically ill persons requiring extended care and a combination of medical-social-personal type services. Medicare's definition of covered home health services also serves to limit the program's usefulness for persons with chronic care needs. The services often cited as most needed to permit an individual to avoid institutionalization—homemaker/chore, home-delivered meals, transportation, and respite care—are the very types of services not covered by Medicare.

Similarly, Medicaid's coverage contains an inherent bias toward institutional rather than home care. As GAO has noted, Medicaid's eligibility policies and restrictive benefits are to blame for creating financial incentives to use nursing homes. State Medicaid programs usually offer more extensive (and often full) coverage for long term care services provided in nursing homes, while Medicaid support to the chronically impaired elderly living in the community is usually quite limited. In addition, certain elderly, ineligible for Medicaid while living in the community, may become eligible once they enter a nursing home, if the State has different income standards for nursing home residents as opposed to community residents.

Others become eligible for Medicaid once they deplete their resources after initially entering the nursing home as privately paying patients. The 1977 CBO report on long term care estimated that 47.5 percent of nursing home patients whose costs were paid by Medicaid in 1974 were not initially poor by State definition but depleted their resources sufficiently to qualify as medically needy.

Changes are needed in public programs to prevent the needless institutionalization of elderly persons who have the potential for independent community living. Studies have consistently pointed to the preference of the impaired elderly to receive services in their own homes or the homes of their families rather than enter a nursing home. In discussing alternatives, some observers have asserted that the community not be viewed as an "alternative"—the institution should be viewed as the alternative to the community. GAO has noted that "in addition to fearing a loss of indepedence, many elderly resist nursing home placement because it often means they must give up their lifelong possessions and sever their community ties; others perceive institutionalization as a prelude to death."

Greater awareness of the need for more extensive home-based care was evidenced in the 96th Congress with passage of certain Medicare provisions in Public Law 96–499, the Omnibus Reconciliation Act of 1980. These provisions removed the "prior hospitalization" requirement that had previously characterized the Medicare home health benefit. Public Law 96–499 also removed the limitations on the number of covered home health visits and exempted home health services from the deductible under Part B of Medicare.

Further progress was made in the first session of the 97th Congress, when Congress recognized the need for greater flexibility in the Medicaid program to allow for payment of more extensive home health services and other community-based long term care. Section 2176 of P.L. 97–35, the Omnibus Budget Reconciliation Act of 1981 permits the Secretary of HHS to waive Federal requirements to enable a State to provide home and community-based services to individuals otherwise requiring nursing home services which would be reimbursed by Medicaid.

The stimulus for such action was provided in part by the findings of demonstration projects in several parts of the country designed to test the benefits, including cost-effectiveness, of community-based long term care services as an alternative to institutional care. The majority of these projects have operated under a combination of funding sources, including waiver authorities under the Medicaid and Medicare programs, as well as authorities under the Older Americans' Act and title XX of the Social Security Act. The waivers have permitted payment by Medicare or Medicaid for services not normally covered, as well as lifting certain eligibility requirements to accommodate participants otherwise ineligible under the programs.

A number of these studies have reported that patients who received home health care experienced higher contentment levels and reduced mortality rates. For example, reports from the Triage program in Connecticut and the On Lok Day Health Services program in San Francisco reveal that participants were significantly more satisfied with their condition than nursing home residents with theirs.

In hearings before this committee, the American Association of Retired Persons/National Retired Teachers Association referred to findings from a recent demonstration project in Georgia—the Alternative Health Services Project—which showed a substantial improvement in life expectancy for persons participating in the program. Project findings indicate that availability of alternative services (ranging from home-delivered services to adult day care) resulted in mortality rates among those Medicaid eligibles in the service group of only 15 percent compared to 29 percent for those in the control group who had access only to those services normally available under the Georgia Medicaid program.

There is also the potential for reduction in public expenditures because home health care and other community-based alternatives can often be provided at a substantially lower cost per day than nursing home care. For example, Dr. Philip Brickner, director of the Chelsea Village Program at St. Vincent's Hospital in New York, reported considerable savings in the use of home care compared to nursing home care. In testimony before this committee, Dr. Brickner contrasted the $833 per month home care costs for an 83-year-old woman with Medicaid's local payments of $2,122 a month for skilled nursing home care. Dr. Brickner found that the costs of long-term care at home average about 40 percent less, even when including the value of rent, food, clothing, telephone, medications, professional health services, and the help of community agencies.

During hearings in 1980 before the House Select Committee on Aging, witnesses on behalf of the adult day care programs sponsored under the Massachusetts Medicaid program testified that their rates for day care services (about $24 per person per day) were significantly lower than nursing home rates (about $44 per day) would have been. It was estimated that at least half of the people in the day care program would have otherwise gone into nursing homes. Testimony from other State programs showed day care costs similar to those of Massachusetts, e.g., Washington, New Jersey, and California have rates below $30 a day.

Other cost-savings potential can be realized through reduced hospital admissions and reduced lengths of stay for patients using home care alternatives. In its testimony before this committee, GAO confirmed that home care has been shown to reduce hospital length of stay and thus potentially produce substantial long-term savings to the Federal Government. GAO noted that, of the studies examined, the estimated average number of hospital days avoided per patient transferred to home services was 13.3 days. These studies reported estimates ranging from an average of 3.5 to 22.6 hospital days saved.

A particularly noteworthy project in this regard is the ACCESS project, in Monroe County, New York, which exercises control over Medicaid nursing home admissions through increased emphasis on a variety of home care services. Implementation of this project has resulted in a reduced growth rate for Medicaid hospital expenditures. This is attributed in considerable part to increased use of home care services by clients who would otherwise have been backed-up in hospitals awaiting discharge or transfer to nursing homes. Medicaid costs for home care have been estimated to cost from 30 to 50 percent of the comparable Medicaid institutional rate.

Testimony before this committee by Mark Blitz, Assistant Director of ACTION, revealed that ACTION's Senior Companion Program has also had a favorable impact on reducing institutionalization. In Minnesota, a recent survey of the Senior Companion Program estimated that 264 of 404 clients served would most likely have been institutionalized were it not for the program.

A further example of the potential cost-effectiveness of home care was provided by testimony from Donald Wortley, of the Council of Home Health Agencies and Community Health Services of the National League for Nursing. Mr. Wortley referred the committee to a study prepared by the Visiting Nurse Association of Greater St. Louis and Blue Cross of St. Louis, Missouri, which estimated that, on the average, $3,000 per patient in hospital costs were saved because of the referral to the VNA and subsequent provision of home care.

Testimony presented by Glen Gee, director of respiratory care services at Loma Linda University in California, revealed reductions in hospital days for patients participating in a hospital-based respiratory therapy program which provides services in the home. Prior to the rehabilitation program, patients were averaging 17 days a year in the hospital. After 1 year on the rehab program, the number of hospital days dropped to 7.78 a year. At the end of 5 years, it had leveled off at about 3.26 hospital days per patient per year. Another demonstration project in Wisconsin also showed reduced hospital and nursing home length of stay for persons in the experimental group.

Further testimony from many persons and organizations spoke to the fear of the elderly who are confronting the possibility of institutionalization. One patient at the Chelsea Village home health care program expressed the sentiments of many when she said, "Thank God you are here, if only you will help me stay out of a nursing home." Older people placed in hospitals or nursing homes when they do not need to be there suffer from the regimentation and lack of independence that is all too common in institutionalized settings. Furthermore, persons in institutions tend to acquire a sense of dependence, and their chances of returning to the community are thus reduced.

Too often it is a small item of assistance that is needed to keep a person at home and out of an institution. Speaking on behalf of expanded home health care services, America's First Lady of the Stage and veteran health care activist, Ms. Helen Hayes testified forcefully regarding "* * * the thousands of elderly Americans who are annually swept into nursing homes, because of some small help that wasn't available at home." Ms. Hayes pointed out that many nursing home patients are there because they have no ground-floor apartment, no home, no help in getting in and out of bed, or an inability to shop, cook, or clean.

In summation, studies on home health and other community-based long-term care services have been conducted throughout the past decade to determine not only the cost-effectiveness but other benefits of such alternatives to institutional care. Reviews by the GAO, DHHS, and other organizations appear to indicate that, at a minimum, home health care can indeed be a cost-effective means of treatment for some groups of people and for some services. The degree of cost-effectiveness appears to be related to the level of physical or mental impairment of the patient. As a DHHS review noted, for slightly impaired people alternatives other than nursing homes are more economical, while for severely impaired people the opposite is true. The report commented that it is unclear from current studies "exactly where the breakeven point occurs, and how to determine for which individuals and subpopulations which particular services and settings are cost-effective." The Committee believes this challenge, of assuring an appropriate, but not excessive, intensity of care setting, can and should be met.

We are now approaching a crossroads where we can either implement the positive findings of these studies or delay further action in the interests of more studies and more experiments. Unless action is taken to change the course of public policy, this committee feels that the future holds no prospect other than increasing reliance on institutional care and consequently increasing costs to the Government as the Nation's population ages.

As a Nation we cannot afford the costs for the numbers of institutions that would be required to care for the increasing numbers of aged and chronically ill dependent people. Nor can we afford to ignore the issue of what human beings are entitled to in their lives. As Ms. Helen Hayes so eloquently noted, "we have lengthened life, now we've got to make those years worth living."

### THE NEED FOR AN INCREASED SUPPLY OF HOME HEALTH PROVIDERS

As part of its interest in promoting and expanding home health care, the committee examined information on the existing supply of home health agencies and trained home health care personnel available to provide services. The supply and distribution of both providers and specific types of service can be critical factors affecting the accessibility of home health services. While home health care providers have grown both in absolute numbers and in numbers of services provided, home health care is still not uniformly available to all Medicare and Medicaid beneficiaries. There is also evidence that certain types of providers are growing more rapidly than others.

Home health providers can be grouped into three broad categories, based on ownership/governing authority:

Public agencies, including all agencies operated by State or local government units;

Nonprofit agencies, including nongovernment tax-exempt organizations such as Visiting Nurse Associations (VNAs) or agencies located in hospitals, Skilled Nursing Facilities (SNFs), or rehabilitation facilities as well as private, nonprofit agencies organized and operated by an individual; and

Proprietary agencies, including all privately owned, profit-making agencies.

Under Medicare, a home health agency is defined as a public or private organization primarily engaged in providing skilled nursing and other therapeutic services. Regulations specify that the agency must provide part-time or intermittent skilled nursing services and at least one other therapeutic service, on a visiting basis, in the patient's place of residence. A public or nonprofit private agency must provide one service directly through its own employees, but may contract for the provision of additional services. Proprietary agencies must provide all services directly.

A 1979 DHEW report to Congress on home health care noted that, in 1963—2 years prior to the enactment of Medicare and Medicaid—fewer than 250 agencies met the definition of a home health agency later set forth by Medicare and also adopted by Medicaid. At that time, 1,163 agencies offered a program of nursing care at home, but only 141 of these met the Medicare program requirement that at least one other therapeutic service be provided. Ninety percent of the agencies offering in-home services were operated by State and local governments and by visiting nursing associations (VNAs). The governmental agencies typically provide educational and referral services but not direct care. The picture changed rapidly with the implementation of Medicare and Medicaid in 1966, and by October of that year, 1,275 home health agencies were certified for participation. Since that time the total number of certified agencies has grown to approximately 3,200 as of January 1982. Table 1 below shows the number of participating home health agencies under Medicare, for selected years 1966–1982.

TABLE 1.—MEDICARE: PARTICIPATING HOME HEALTH AGENCIES, SELECTED YEARS, 1966–82

| Year [1] | All agencies | Official health agency [2] | Visiting nurse association | Combined government and voluntary agency | Hospital-based program | Other |
|---|---|---|---|---|---|---|
| 1966 | 1,275 | 579 | 506 | 83 | 81 | 26 |
| 1970 | 2,311 | 1,334 | 552 | 102 | 202 | 121 |
| 1975 | 2,254 | 1,259 | 530 | 47 | 270 | 148 |
| 1982 | 3,178 | 1,225 | 515 | 54 | 444 | 904 |

[1] As of October 1966, as of January 1970, 1975, and 1982.

[2] An agency administered by a State, county, or other local unit of government.

[3] Includes skilled nursing facility-based programs, rehabilitation facility-based programs, proprietary, or other home care programs. For 1982, the 904 agencies include 332 proprietary, and 551 private nonprofits.

Source: U.S. Department of Health, Education, and Welfare. Health Resources Administration. "Health Resources Statistics; Health Manpower and Health Facilities 1976–77," p. 394, and unpublished data of the Health Care Financing Administration for 1982.

Table 2 below provides a further breakdown of those agencies, by DHHS region, State and type of agency, certified to participate in Medicare as of January 1982.

TABLE 2.—MEDICARE: PARTICIPATING HOME HEALTH AGENCIES, BY STATE, BY TYPE OF AGENCY, JANUARY 1982

| HHS region and State | Number of active, participating HHA's | Visiting nurse association | Combined government and voluntary agency | Official health agency [1] | Rehabilitation facility-based program | Hospital-based program | SNF-based program | Proprietary | Private nonprofit |
|---|---|---|---|---|---|---|---|---|---|
| Total, all locations | 3,178 | 515 | 54 | 1,225 | 11 | 444 | 10 | 332 | 551 |
| Region I | 285 | 196 | 1 | 42 | 0 | 25 | 0 | 3 | 16 |
| Connecticut | 86 | 58 | 0 | 18 | 0 | 6 | 0 | 3 | 1 |
| Maine | 12 | 5 | 0 | 0 | 0 | 1 | 0 | 0 | 5 |
| Massachusetts | 116 | 79 | 0 | 19 | 0 | 14 | 0 | 0 | 3 |
| New Hampshire | 39 | 32 | 1 | 1 | 0 | 1 | 0 | 0 | 4 |
| Rhode Island | 12 | 9 | 0 | 0 | 0 | 2 | 0 | 0 | 1 |
| Vermont | 20 | 13 | 0 | 4 | 0 | 1 | 0 | 0 | 2 |
| Region II | 208 | 38 | 5 | 74 | 0 | 53 | 2 | 1 | 33 |
| New Jersey | 47 | 22 | 1 | 15 | 0 | 8 | 0 | 0 | 0 |
| New York | 122 | 15 | 3 | 57 | 0 | 42 | 2 | 0 | 1 |
| Puerto Rico | 38 | 1 | 1 | 1 | 0 | 3 | 0 | 0 | 32 |
| Virgin Islands | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Region III | 286 | 69 | 1 | 78 | 1 | 49 | 1 | 38 | 36 |
| Delaware | 7 | 1 | 0 | 3 | 1 | 1 | 0 | 0 | 1 |
| District of Columbia | 6 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 2 |
| Maryland | 51 | 2 | 0 | 17 | 0 | 7 | 0 | 18 | 7 |
| Pennsylvania | 130 | 58 | 0 | 2 | 0 | 36 | 0 | 6 | 22 |
| Virginia | 61 | 4 | 1 | 38 | 0 | 2 | 1 | 14 | 0 |
| West Virginia | 31 | 3 | 0 | 17 | 0 | 3 | 0 | 0 | 4 |
| Region IV | 747 | 22 | 21 | 324 | 2 | 61 | 1 | 88 | 226 |
| Alabama | 95 | 2 | 0 | 60 | 0 | 4 | 1 | 2 | 26 |
| Florida | 134 | 14 | 2 | 11 | 0 | 6 | 0 | 31 | 70 |
| Georgia | 63 | 2 | 1 | 8 | 0 | 7 | 0 | 1 | 44 |
| Kentucky | 54 | 1 | 1 | 22 | 0 | 16 | 0 | 7 | 6 |
| Mississippi | 132 | 0 | 0 | 84 | 1 | 15 | 0 | 0 | 32 |
| North Carolina | 90 | 1 | 1 | 55 | 0 | 8 | 0 | 7 | 18 |
| South Carolina | 33 | 0 | 0 | 15 | 1 | 3 | 0 | 7 | 6 |
| Tennessee | 146 | 2 | 16 | 69 | 0 | 2 | 0 | 33 | 24 |
| Region V | 557 | 89 | 11 | 263 | 3 | 74 | 3 | 30 | 76 |
| Illinois | 139 | 24 | 1 | 38 | 0 | 28 | 0 | 8 | 40 |
| Indiana | 47 | 17 | 0 | 12 | 0 | 6 | 0 | 8 | 3 |
| Michigan | 64 | 11 | 1 | 31 | 0 | 6 | 0 | 0 | 15 |
| Minnesota | 93 | 2 | 2 | 64 | 1 | 10 | 3 | 2 | 5 |
| Ohio | 114 | 21 | 5 | 61 | 0 | 15 | 0 | 0 | 10 |
| Wisconsin | 100 | 14 | 2 | 57 | 2 | 9 | 0 | 12 | 3 |
| Region VI | 410 | 17 | 0 | 176 | 1 | 38 | 0 | 91 | 83 |
| Arkansas | 101 | 1 | 0 | 75 | 0 | 12 | 0 | 0 | 13 |
| Louisiana | 85 | 0 | 0 | 33 | 1 | 8 | 0 | 34 | 9 |
| New Mexico | 30 | 6 | 0 | 1 | 0 | 12 | 0 | 8 | 3 |
| Oklahoma | 78 | 2 | 0 | 56 | 0 | 2 | 0 | 4 | 13 |
| Texas | 116 | 8 | 0 | 11 | 0 | 4 | 0 | 45 | 45 |
| Region VII | 263 | 20 | 10 | 156 | 0 | 37 | 2 | 5 | 30 |
| Iowa | 107 | 12 | 3 | 87 | 0 | 4 | 0 | 0 | 1 |
| Kansas | 70 | 3 | 4 | 42 | 0 | 9 | 0 | 1 | 8 |
| Missouri | 68 | 4 | 2 | 27 | 0 | 9 | 1 | 4 | 21 |
| Nebraska | 18 | 1 | 1 | 0 | 0 | 15 | 1 | 0 | 0 |
| Region VIII | 125 | 10 | 2 | 62 | 3 | 23 | 0 | 6 | 17 |
| Colorado | 57 | 7 | 1 | 25 | 2 | 2 | 0 | 4 | 15 |
| Montana | 17 | 1 | 1 | 7 | 1 | 5 | 0 | 0 | 2 |
| North Dakota | 15 | 0 | 0 | 5 | 0 | 9 | 0 | 1 | 0 |
| South Dakota | 6 | 1 | 0 | 2 | 0 | 3 | 0 | 0 | 0 |
| Utah | 10 | 1 | 0 | 6 | 0 | 3 | 0 | 0 | 0 |
| Wyoming | 20 | 0 | 0 | 18 | 0 | 1 | 0 | 1 | 0 |
| Region IX | 212 | 49 | 3 | 21 | 1 | 58 | 1 | 63 | 15 |
| Arizona | 18 | 4 | 0 | 6 | 0 | 6 | 0 | 1 | 1 |
| California | 174 | 43 | 3 | 10 | 1 | 43 | 0 | 59 | 14 |
| Hawaii | 9 | 0 | 0 | 2 | 0 | 5 | 1 | 1 | 0 |
| Nevada | 10 | 2 | 0 | 2 | 0 | 4 | 0 | 2 | 0 |
| Guam | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |

See footnote at end of table.

TABLE 2.—MEDICARE: PARTICIPATING HOME HEALTH AGENCIES, BY STATE, BY TYPE OF AGENCY, JANUARY 1982—Continued

| HHS region and State | Number of active, participating HHA's | Visiting nurse association | Combined government and voluntary agency | Official health agency[1] | Rehabilitation facility-based program | Hospital-based program | SNF-based program | Proprietary | Private nonprofit |
|---|---|---|---|---|---|---|---|---|---|
| Region X | 85 | 5 | 0 | 28 | 0 | 26 | 0 | 7 | 19 |
| Alaska | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Idaho | 14 | 0 | 0 | 4 | 0 | 6 | 0 | 4 | 0 |
| Oregon | 37 | 1 | 0 | 15 | 0 | 13 | 0 | 3 | 5 |
| Washington | 33 | 4 | 0 | 8 | 0 | 7 | 0 | 0 | 14 |

[1] An agency administered by a State, county, or other local unit of government.

The 1979 DHEW report to Congress on home health included data that showed home health agencies are more readily available to residents of metropolitan than metropolitan counties. In the Northeast, where the greatest percentage of Medicare beneficiaries live in metropolitan counties, the availability of home health agencies is nearly universal. But in other regions, agency and service availability is considerably less, particularly in nonmetropolitan, rural areas. Testimony received in hearings before this committee noted that over 600 of the 3,105 counties in the United States are without a home health agency certified to participate in Medicare. Most of these counties were said to be rural areas with widely-dispersed populations.

The uneven geographic development of home health agencies is also reflected in service utilization by Medicare beneficiaries. Regional utilization data for 1979 indicate that the Northeast region had the highest visit rate among the regions—980 per 1,000 enrollees. The South had the second highest—669 per 1,000 enrollees. The West experienced 554 visits per 1,000 enrollees while the North Central region had the lowest rate of 533 per 1,000 enrollees. These differences in utilization may reflect differences in the demand for services by the Medicare population in various geographic areas, as well as the available supply of home health providers eligible to participate in the program.

Another factor to be considered in planning for the development of home health agencies is the increasing mobility of the elderly. As a witness for the Home Health Services and Staffing Association pointed out to this committee,

> The elderly are mobile, moving, as one might suspect, from north to south, and more importantly, from metropolitan to non-metropolitan areas: in other words, the elderly are moving from areas which have a variety of health services to areas which are underserved or completely unserved.

Availability of a provider does not necessarily mean that a particular needed home health service will also be available. Table 3 below shows that, of the number of home health agencies certified to participate in Medicare as of January 1981, only about 40 percent offered occupational therapy or medical social services.

TABLE 3.—MEDICARE: PARTICIPATING HOME HEALTH AGENCIES OFFERING SELECTED SERVICES, MARCH 1967 AND JANUARY 1981

| Service | 1967 | | 1981 | |
|---|---|---|---|---|
| | Number | Percent of total | Number | Percent of total |
| Total | 1,753 | 100.0 | 3,042 | 100.0 |
| Nursing care | 1,753 | 100.0 | 3,042 | 100.0 |
| Physical therapy | 1,201 | 68.5 | 2,405 | 79.1 |
| Occupational therapy | 244 | 13.9 | 1,194 | 39.3 |
| Speech therapy | 361 | 20.6 | 1,683 | 55.3 |
| Medical social service | 400 | 22.8 | 1,262 | 41.5 |
| Home health aide service | 601 | 34.3 | 2,770 | 91.1 |

Source: U.S. Department of Health, Education, and Welfare. Health Resources Administration. "Health Resources Statistics; Health Manpower and Health Facilities 1975," p. 452; and unpublished data of the Health Care Financing Administration, January 1981.

Government assistance for the development and expansion of home health agencies has been available since 1962. The first authority was contained in the Community Health Services and Facilities Act in 1961. This was followed by the enactment in 1975 of the Health Revenue Sharing and Health Services Act (P.L. 94–63), which established a home health services grant program later codified as section 339 of the Public Health Service Act. Grants were authorized to public and nonprofit private entities for a variety of purposes including: (1) meeting the initial costs of establishing home health agencies, (2) expanding the services available through existing agencies, (3) compensating personnel during the period between start-up and full agency operation, and (4) training personnel in the provision and administration of home health services.

All but two of the service projects resulted in agencies which subsequently became certified for participation in Medicare. All of the grants were awarded on a one-time only basis (85 grants for new programs, 260 for expansion of existing ones). The training grants resulted in the training of 8,000 home health aides and 2,200 administrative personnel.

Some have noted that home health agencies do not generally require large initial capital investments and that start-up costs can be reimbursed under Medicare and Medicaid like any other expense. However, this fails to account for the fact that current cost-based retrospective reimbursement arrangements under Medicare make it impossible for agencies to recover amounts beyond their actual expenses. As one witness before this committee noted, "the accumulation of capital to support expansion or improvement of services is largely precluded unless other purchasers of home care services provide recognition of these capital requirements; therefore, the grant . . . program can provide a vital source of capital which is essential to the maintenance and growth of many home health agencies which have no other source of capital."

There are reportedly few sources of private funds for starting up home health agencies, although certain proprietary chains appear to

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be successful in establishing themselves in concentrated urban areas. Few proprietaries appear interested in entering rural areas, which are generally more difficult to serve. For those counties without a Medicare-certified home health agency, a public or private nonprofit agency may be the only answer. However, public and private nonprofit agencies reportedly encounter more difficulty in locating capital development funds in the private money market and have therefore looked to public programs such as the section 339 grant program for start-up or expansion assistance.

It might also be noted that many of the existing home health agencies today are relatively small-scale operations. Of the 3100 home health agencies certified by Medicare as of July 1981, 1690 employ less than 5 full-time nurses. Any expansion in home health coverage under Medicare and Medicaid is likely to place additional pressures on the existing network of providers.

Attention must therefore be paid to the need to expand our supply of trained home health service personnel. Recognition of this need was contained in provisions in P.L. 96–499, the Omnibus Reconciliation Act of 1980, which authorized 12 State demonstration projects for the training of AFDC recipients as home health aide/homemakers. However, it is understood that only two such training projects will be operational in 1981.

It has been noted that the problem of adequate, trained home health personnel is particularly acute in rural areas. Medicare requires that the patient be in need of skilled care in order to receive services, and the skilled care must be provided by a registered nurse. However, in rural areas it is difficult to find enough people to train as home health aides and even more difficult to find registered nurses. As a consequence, many agencies try to serve rural areas from their main offices in metropolitan areas. This requires that employees travel great distances to serve patients, and thus adds to the cost of the program.

Testimony before this committee by the National Home Caring Council noted that most paraprofessional homemaker-home health aides come to the job without a high degree of formal education and/or without a prior employment history. Yet such aides render a substantial proportion of direct patient care. Provision of basic skills training to these individuals is key to their ability to perform services effectively and efficiently under professional supervision and key to consumer protection for safe service. A number of States have added requirements concerning the training and supervision of home health aides to Medicare's conditions of participation for home health agencies. Other States require training for home health aides in their licensure requirements.

## THE NEED TO STUDY REIMBURSEMENT ALTERNATIVES FOR HOME HEALTH AGENCIES

As the Committee examines methods to expand both the coverage and availability of home health services, the Committee was also concerned that certain problems associated with the home health industry be addressed, namely poor incentives in the reimbursement system to minimize cost and the potential for fraud and abuse by providers participating in the program. As GAO noted before this Committee, the Medicare reimbursement system is relatively open ended and susceptible to abuse. Review of home health care operations is often difficult due to the providers' lack of a sophisticated data base. In addition, it has been charged that fiscal intermediaries not only receive inadequate information from providers for purposes of claims review, but also fail to monitor agencies closely enough to insure that the services claimed are actually reimbursable.

Home health agencies are paid during the year based on estimated costs, but final settlements are limited to those costs found by intermediaries to be proper, reasonable, and related to patient care. Final cost settlements can often take two or more years. As one witness noted,

> In effect home health agencies provide a service in one month but the price of that service is determined many months later, often two or three years later and often following much negotiation between the provider and HCFA officials.

Reimbursement of home health providers is presently characterized by wide variations among providers in the unit costs of similar services and the related problems in determining whether costs at the higher end of the range are reasonable. Other problems occur because the recordkeeping procedures of some providers are not detailed enough to generate the information necessary to determine whether the services that have been claimed are allowable under Medicare. GAO has reported data from HCFA showing that 8 percent of the certified home health agencies fail to maintain adequate clinical records.

Criticisms of the present home health reimbursement system raised in testimony before this committee included the following:

There are no cost containment incentives;

The reporting requirements are burdensome, but cannot prevent fraud;

Reasonable cost is not uniformly interpreted by fiscal intermediaries;

When used by self-serving individuals, fraud is possible;

The system is difficult to administer;

Cost report manual instructions are applied retroactively;

The system does not allow profits for all types of providers; and

The new single "step-down" method of cost finding is not flexible enough to provide for the uniqueness among providers.

A report just issued by the Permanent Subcommittee on Investigations of the Senate Committee on Governmental Affairs found that, for Medicare's home health care benefit, the "present retrospective cost reimbursement system is a very poor system which easily lends itself to abuse."

This committee is equally concerned about the need to institute fair, cost-effective reimbursement procedures which will prevent federally-reimbursed providers from exploiting loopholes in the Medicare law and profiting at the expense of the taxpayer, while threatening the well-being of those intended beneficiaries. The potential for abuse, in the Committee's view, should be confronted directly, rather than being used as an excuse for Congressional inaction.

## THE NEED TO ENCOURAGE FAMILIES TO CARE FOR THE ELDERLY IN THEIR HOMES

While it is difficult to assess the full extent of private informal care provided by family members, studies have shown that it is generally families, not the government, that provide the most care for the elderly. The Health Care Financing Administration has estimated that between 60 and 80 percent of the care received by the impaired elderly is provided by family members or friends who are not compensated.

However, demographic changes such as the increasing divorce rate and the decline in the birth rate, as well as the increasing participation of women in the work force, are likely to have an impact on the continued ability of families to provide care for their elderly dependents. An additional factor is that present public policy artificially lowers the cost to family members of institutional care relative to other forms of care for the chronically ill elderly. For example, adult children presently have no financial liability for an elderly parent once that parent enters a nursing home as a Medicaid patient.

Efforts must be made to support families that wish to continue caring for their elderly dependents at home rather than turning to institutional care provided under public programs. As discussed earlier, changes in Medicare/Medicaid coverage of home health care is an important step in this direction. This effort could be enhanced if financial incentives were available to encourage family cooperation in the home support of the elderly. A December 1981 report on long term care by the Service Delivery Assessment unit in DHHS' Office of the Inspector General found strong support for the idea of tax incentives for families providing care at home to their elderly and disabled members.

Although some fear that expansion of home health care under public programs will discourage rather than encourage family and friends from providing informal support services, experience with the home care program at St. Vincent's Hospital has shown this to be untrue. As Dr. Philip Brickner of the Chelsea Village program noted, "family and friends are often scared away when the needs of a homebound elderly person begin to multiply; our staff has provided a reassurance to these informal care givers." It was reported that 83.5 percent of the Chelsea Village patients received assistance from a relative or friend. A sampling of home care patients in Minnesota indicates involvement of a family member or friend for 78 percent of the cases. It is evident that home health care can actually encourage informal care givers to continue their assistance.

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## Committee Views

### SECTION 3. TITLE III OF THE PUBLIC HEALTH SERVICE ACT

Over the last 20 years, federal assistance has made possible the development and expansion of home health service programs throughout the country. Although the level of support available under Title III of the Public Health Service Act for home health programs has been relatively modest compared to other federally supported programs ($6 million in FY '79, $5 million in FY '80 and no funds were appropriated in FY '81), the assistance provided has benefited communities and individuals who would otherwise not have had access to such services. The Committee has received testimony indicating the difficulties home health agencies have encountered in initial start-up or expansion in underserved areas (i.e. rural, urban-inner city and areas which have experienced a large influx in the numbers of citizens over 65.)

The Committee believes that this program of assistance for home health should emphasize the priority the Committee feels should be placed on development of home and community services as an alternative to institutional care of the elderly and disabled.

For these reasons the bill which the Committee has reported amends Title III of the Public Health Service Act to provide assistance for the development of home health agencies.

*Grants and loans for home health programs*

The Secretary is authorized to make grants to public and non-profit entities and loans to proprietary entities to cover the start-up costs of establishing and operating home health programs in areas that are currently underserved. The committee expects that the Secretary, when making grants and loans under this authority, will consider the relative need for these services and give preference to areas where there is a high percentage of elderly, medically needy or disabled citizens, areas which have inadequate home health services and means of transportation to obtain health services. In making loans to proprietary entities the Secretary must also receive satisfactory assurances that the applicant is fiscally sound at the time the application is made, that the applicant will be able to repay the loan, and that the applicant could not secure a loan for this purpose from non-Federal sources. Authority for this section shall be $5 million for grants and loans for each of the fiscal years ending September 30, 1983 and September 30, 1984.

*Grants and contracts for training home health personnel*

The Committee believes that the expansion of quality home health services requires particular attention to the development of appropriate training techniques and programs to assure an adequate and properly trained supply of professional and paraprofessional service providers. The Committee recognizes this need and authorizes the Secretary to make grants to and enter into contracts with public and private entities to assist in the development of training programs which are consistent with the Committee amendments to Section 1861(m) of the Social Security Act.

Testimony presented on November 10, 1981, reported that the "Mini-White House Conference on Long-Term Care" (Dec. 80) encouraged senior citizen participation in providing health care. The testimony continued by saying, "we believe that involving those older persons whose health permits it in providing home care will prove to be a meaningful source of badly needed personnel as well as create the opportunity for very important work by many senior citizens." The Committee concurs with this statement and directs the Secretary to give special consideration in the awarding of grants and contracts for training programs to entities which establish programs to provide training for persons fifty years of age to provide homemaker/home health aide services.

Authority for this section shall be $2 million for grants and contracts for each of the fiscal years ending September 30, 1983 and September 30, 1984.

*Secretary's report on impact of home health agencies*

The Secretary shall report on or before January 1, 1984 to the Senate Labor and Human Resources Committee and the Committee on Energy and Commerce of the House of Representatives regarding the following: impact made by grants and contracts provided under subsections (a) and (b) prior to October 1, 1981, in providing and developing home health services in underserved areas and the continued need for start-up grants as provided in this Act; the extent which standards for training as outlined in Section 1861(m), as amended by this Act, are applied; and the extent to which training costs could be or are reimbursed under Titles XVIII and XIX of the Social Security Act. Since fraud and abuse by some providers can be a major obstacle to expansion of home health services, the Committee directs the Secretary to include in this report efforts by the Department to curtail fraud and abuse with respect to services provided under this section and Titles XVIII and XIX of the Social Security Act.

### B. SOCIAL SECURITY ACT—MEDICARE AND MEDICAID PROVISIONS

> Old age * * * is more likely to be associated with disease and disability than any other period in the life span. It follows that medical problems of old age should command high priority in resource expenditures if a society wishes not only to provide for its older members as each of us would be provided for, but also if it is to avoid the economic burden of a vast mass of disabled old people. (Brocklehurst, 1974, p. 2).

One in every 10 Americans is over 65. By the year 2000, 1 in 8 will be over 65. As the number of older citizens increases, the need for alternatives to present chronic and acute health care systems becomes apparent. The emphasis in public policy has been placed primarily on nursing homes and hospitals as the principle means of dispensing care to chronically ill, older Americans.

For an increasing number of Americans home health care is an appropriate alternative to these more costly approaches. In Elaine Brody's article "The Aging Family" she reports that

> The dramatic increase in the number and proportion of old people, particularly of very old people, had resulted in a phenomenon new to our time: more families as a whole are aging and old. There now exists many families in which the adult children as well as the parent are in the aging phase of life.

But despite this fact she further reports the

> myth that there is widespread abandonment of the current generations of older people by their families has been disproved by research and clinical evidence, but it stubbornly refuses to be dispelled in popular belief.

Families want and often do care for ailing and older family members, but financial and emotional strains caused by long-term care often forces them to resort to placement in long-term care facilities.

On November 10, 1981, testimony before this Committee reported that

> Those who are engaged in providing health care to individuals in their homes have long recognized both the cost-effectiveness and the appropriateness of this delivery system for many individuals who might otherwise be sent to institutions.

It is the belief of this Committee that given support in the care of the elderly, families will be more willing to shoulder the responsibility for care. In addition, home health care can assist the elderly citizen who may live alone, and have functional disabilities or disabilities caused by disease, to maintain their independence and avoid early or unnecessary institutionalization. Those senior citizens who prefer to stay at home and could do so with appropriate support should be given that opportunity. It is for these reasons that S. 234 the Community Home Health Services Act of 1981 includes the following amendments to the Social Security Act.

### SECTION 4

*Medicare and medicaid provisions*

In the course of its hearings, the Committee learned that the availability of appropriate home health services, many elderly and disabled persons would be able to remain in the community, rather than having to resort to costly and unnecessary institutional care in nursing homes and hospitals. Yet limitations on existing Medicare reimbursement often prove an obstacle to maintaining the elderly and disabled in the home. The Committee has determined that several such obstacles are particularly deserving of legislative attention.

*Qualifying criteria*

An individual is currently eligible for home health services only if that individual also requires additional skilled services, such as skilled nursing care on an intermittent basis or speech or physical therapy.

Individuals who need only homemaker/home health aide services or respiratory or occupational therapy are not eligible for home health services, even though, in the absence of these services, they will require institutionalization. Failure to provide home health services in these cases is a serious waste of resources and can have a tragic impact on the health and well-being of those affected.

Accordingly, the Committee has determined to amend §§ 1814 and 1835 of the Social Security Act to provide that the need for homemaker/home health aide services, or for occupational or physical therapy, are qualifying services, if, in the absence of such services, the individual would require institutionalization. In all other respects, the qualifying criteria (such as the requirement that the individual be confined to the home, or that a plan of care be established) are unchanged.

The Committee believes that, while it is appropriate to expand the availability of home health services to these individuals, it is also appropriate that they share in the cost of the services. Accordingly, the Committee has provided that for individuals who qualify for home health services solely by virtue of their need for homemaker home health aide services or by virtue of their need for occupational or respiratory therapy, reimbursement for homemaker/home health aide services shall be limited to 50% of the amount that would otherwise be paid.

*Scope of services*

Current Medicare law permits reimbursement for home health aide services for individuals who qualify for home health services. This definition artificially restricts the scope of services which may be essential to the individual's ability to remain in the home. Testimony before the Committee establishes that personal and household care can be equally important as "skilled services" in assuring the health

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of the elderly and disabled. Accordingly, the Committee has broadened the scope of home health services which may be reimbursed under Medicare to include personal and household care services which promote the functional independence of the eligible individual. Such services do not include structural changes to the home.

It is not the intent of the Committee to replace personal and household care already provided by family members, friends or community sponsored groups or programs. Therefore, before these services can be reimbursed by Medicare a thorough review of available support systems will be conducted by the physician. Communities, charitable organizations, state and local agencies have programs or knowledge of programs that provide assistance and care to elderly citizens in their homes and would be a valuable source of information to physicians in preparing the plan of care.

The Committee, concerned about the quality of these newly expanded homemaker/home health aide services, has included a provision requiring that aides and homemakers meet certain training standards, either by completing 40 hours of formal training or demonstrating an equivalent amount of training by work experience, testing or licensure. In addition, because these services are designed to promote the functional independence of the individual receiving care, the services of the homemaker/home health aide must be carried out under appropriate professional supervision, i.e. a geriatric nurse practitioner, registered nurse or physician. This provision is meant to assure that expanded services will be provided subject to proper supervision and within appropriate quality standards.

Nutrition services provided by a qualified dietitian can be an integral part of all home health care programs and be reimbursed as such under this Act. The number of clients with diseases which require treatment for arteriosclerosis, hypertension, diabetes, renal failure and cancer, often ranges from 60% to 90% in home health programs. Understanding and adherence to prescribed dietary regimes is essential to the maintenance of patients' health and will thus reduce the incidence of rehospitalization, which will combat escalating Medicare costs. In the same light, upon discharge from an acute care facility, a patient supported by dietary or other services would be able to return to their home for recovery rather than to an institutional setting. Reimbursable services by a qualified dietitian monitoring clients with diseases which require dietary modification are critical to ensuring the maintenance of the patient's health at home and would reduce the incidence of rehospitalization.

*Transportation*

The Committee learned in testimony that assistance in meeting the costs of transportation for doctor visits or diagnostic testing may be all that is needed to maintain a patient at home. In addition, providing assistance in meeting transportation costs to centralized facilities in rural or remote population centers may be more cost-effective than providing a service at home. In these cases, the Committee determined that limited reimbursement for transportation costs (including costs for transportation by a family member or professional) would promote the Committee's intention to foster cost-effective home based care.

*Single cost limits*

Current Medicare regulations provide separate cost limits for reimbursement of free-standing and for provider-based home health agencies. The Committee recognizes that some of the disparity in costs between free-standing and provider-based agencies can be attributed to current Medicare procedures for allocating hospital overhead costs to home health services. Nevertheless, the Committee believes that establishing a single schedule of cost limits for home health providers under Medicare will promote the cost-effective provision of needed services. Furthermore, continuing dual cost limits may foster further inequities in patient selection, and result in duplication of services within a community.

The Committee believes that only those overhead costs attributable to the hospital or multi-service home health department should be reflected in the Medicare cost report, and directs the Secretary to examine whether any adjustment is warranted in the Department's regulations governing the allocation of costs. The Committee intends that the single schedule of cost limits not be implemented until this review is completed.

*Definition of home health agency*

Under existing law, all providers must satisfy the criteria set forth in § 1861(o) of the Social Security Act in order to qualify for Medicare reimbursement for home health services. The Committee received testimony from some providers indicating that this requirement could prove a barrier to the expansion of home health services, particularly by hospital based providers. The Committee believes that the provisions of § 1861(o) should be generally applicable to both hospital-based and free-standing agencies, but recognizes that in some cases a limited waiver of these requirements may be justified. Accordingly, the Committee has provided that the Secretary may waive the requirement that home health services be provided by a home health agency (as defined in § 1861(o)), but only if the entity seeking the waiver demonstrates that it can substantially comply with the definition of a home health agency and the Secretary determines that the entity can assure the quality and the cost-effectiveness of home health services provided by the entity seeking the waiver.

*Homemaker/home health aide services under medicaid*

S. 234 amends Section 1902(a)(9) of the Social Security Act to provide that all homemaker/home health services under Medicaid must be provided by homemaker/home health aides who have met the requirements set forth in the Committee's amendment to Medicare (Section 1861(m)(4)(A) of the Social Security Act.) It is the intent of the Committee to provide consistent requirements for the training of homemaker/health aides in both the Medicare and Medicaid programs. The Committee does not intend, however, to modify the scope and extent of mandatory or optional services that the states offer in their Medicaid programs.

*Reimbursement studies*

Home health agencies certified to provide services to Medicare beneficiaries include public, proprietary, voluntary, and private nonprofit agencies that are primarily engaged in providing skilled nursing and other therapeutic services in the home. Types of agencies include: (1) visiting nurse associations; (2) subdivisions of State or local health departments; (3) combinations of visiting nurse associations and local health departments; and (4) home health care divisions of hospitals or other health care institutions. Private organizations which do not qualify as nonprofit groups (exempt from Federal income taxation under Section 501 of the Internal Revenue Code of 1954) must be licensed under State law to be considered for certification as home health agencies under Medicare. In addition to the different types of providers of home health care services, each provider also differs in its organization, structure, payor sources, services provided, patients, and administrative sophistication, which in turn effects the proper implementation of the current home health care reimbursement system.

Medicare payments to home health agencies are based on the lesser of reasonable cost or customary charges. The agencies are then paid based on these estimated costs, and final settlements are limited to those costs found by intermediaries to be proper, reasonable, and related to patient care. Final cost settlements can at times take as long as two or three years. A common point raised by various providers of services in both oral and written testimony was that it was very difficult to properly provide services when a home health care entity has no idea what they will be paid for those services until two years later.

In addition, when this cost finding process is completed and a cost per visit computed, federal cost limits are applied to each type of reimbursable services (e.g., skilled nursing care, physical therapy, home health aid, etc.) furnished by the home health agency. These limits are classified according to the type of home health agency, and the classification is based on whether a home health agency is provider-based or free-standing and where the agency is located. Therefore, not only do home health care providers differ in their characteristics, but they also differ in the amount of reimbursement available to them.

The Committee listened to and complied from the two days of hearings on S. 234 various problems inherent in the current reimbursement system, and suggestions for solutions and revised implementation of reimbursement mechanisms to provide the most effective method of home health care. Virtually all sources active in the home health industry (the payor of services, the provider of services, as well as the recipient of service) mentioned areas in the reimbursement methodology that need improvement. Among them are:

Defiinitions are inadequate and unclear, resulting in incorrect or confused interpretation of the regulations by intermediaries, health care practitioners and agencies (e.g., what is proper, reasonable, related to patient care, homebound);

There are no cost containment incentives;

The reporting requirements are burdensome, yet do not prevent fraud;

Reasonable cost is not uniformly interpreted by fiscal intermediaries;

The system is awkwardly organized and difficult to administer;

Cost report manual instructions are applied retroactively;

The single method of cost finding is not flexible enough to provide for uniqueness among providers;

Intermediaries, although they process and pay home health bills, have little knowledge or understanding of the home health benefit;

Experimentation on differing types of reimbursement should be done, to include but not be limited to capitation payments, prospective reimbursement, fee schedules.

In addition to the areas already mentioned that influence the reimbursement process, there were other equally important factors that were brought to the attention of the Committee and should be included in any future analysis:

Physicians who authorize program services do not appear to be taking a very active role in the home health program, due to either a lack of information, lack of time or lack of incentive.

Medicare contractors had little specific comparative information about the utilization practices of home health agencies.

The medical documentation in agency case files was often not complete, and that many certified Home Health Agencies failed to maintain adequate clinical records.

The intermediaries lacked access to proper medical records to substantiate claims.

HCFA has the capability to generate comparative data on home health utilization but does not use this capability to its full potential.

Systems for early identification of patients expected to require long term care need to be developed or, where they exist, strengthened.

Institutional providers prefer the least disabled individuals and there are no incentives to encourage providers to accept patients who require maintenance care.

The Committee therefore feels that a proper consideration of these factors in the current reimbursement system should be an integral portion of any new study of reimbursement mechanisms. The Committee also feels that the Secretary should not limit the Department's study to only the primary participants (private payors, intermediaries, agencies and hospitals), but should also include the secondary participants (physicians, nurses, therapists, program administrators, social workers, client assessment teams, family, etc.)

### *Alternatives and recommendations*

The problems related to the provision of home health care are changing, and the solutions, therefore, need to be flexible. The changes must come from every participant in the system of home health care delivery and services, but in differing proportions. Comprehensive experimental reimbursement mechanisms need to be tested in a variety of settings, taking into account the difference in population, location and resources that occur throughout the nation. No one method will provide a universal solution to the labyrinth of overlapping programs, agencies and needs. In fact, the Committee heard numerous experts testify that indeed there must be a rekindled active involvement on the community and family level for a comprehensive long term care system to work. Among the various programs that received words of praise in their efforts to encourage local responsibility and to experiment with new implementation procedures to provide such care were the St. Vincent's/Chelsea Village Program in New York, the ACCESS programs in Monroe County in New York and the On Lok program in San Francisco, the Five Hospital Home Bound Elderly Program in Chicago, and numerous other established or newly established programs across the nation. One particularly interesting initiative that was brought to the attention of the Committee was the local-area management organization (LAMO), based on a position paper prepared for the National Aging Research Planning Panel, National Institute on Aging. The LAMO program recognizes that exclusive utilization of public financing may no longer be a feasible or acceptable option and has incorporated the lessons from previous public and private programs into a workable system of care involving private (family and community), local, state, and federal support in differing proportions. The Committee feels that these programs are steps in the right direction, and should be thoroughly explored. Undoubtedly many other innovative programs using similar or different models exist and the Department should also explore these.

In addition, the Committee feels that the demonstration projects studied or developed should identify relevant factors to ensure program integrity via the effectiveness of the services being purchased. The demonstrations should also utilize known statistical methodologies for determining norms, ranges and modes for grouping or categories of providers, costs, or application of rates. The studies should also be sensitive to the effectiveness of the program and provide incentives to the most efficient providers, not only those home health agencies with the lowest costs.

### SECTION 5—REFUNDABLE INCOME TAX CREDIT

*Present law*

Under the present income tax laws, there is no provision allowing a deduction or credit specifically for the expenses of supporting and providing health care in the taxpayer's home for a disabled dependent who would otherwise require institutionalization. Some of these expenses, however, may qualify for the medical expense deduction or the tax credit for dependent care services. The medical expense deduction is allowed under section 213 of the Internal Revenue Code for expenses paid for the medical care of a taxpayer, his spouse and dependents that exceed 3 percent of the taxpayer's adjusted gross income for the year. The tax credit for dependent care services is allowed under section 44A of the Internal Revenue Code for expenses incurred by a taxpayer for the care of, among others, a spouse or dependent who is physically or mentally incapable of caring for himself, where such expenses enable the taxpayer to be gainfully employed. The maximum credit allowed is $720 where one individual is cared for, and $1,400 where two or more individuals are cared for; these amounts are reduced on a sliding scale as an individual's adjusted gross income exceeds $10,000. The credit is not refundable.

The Internal Revenue Code, section 43, also allows a tax credit, which is refundable, to low income workers who have families and maintain households. This is a credit of 10% of the first $5,000 of earned income for a maximum credit of $500. The credit is phased out as earned income rises above $6,000 and eliminated when it reaches $10,000.

*Reasons for change*

Other provisions of this bill extend Medicare and Medicaid coverage to certain services required by elderly individuals who are homebound because of illness or disability. The committee believes that in addition to these Medicare and Medicaid changes, tax incentives are needed to make home health care for the elderly an attractive alternative to nursing homes or other institutions.

Many elderly individuals who are homebound would prefer not to go into nursing homes, but instead to stay in their own homes or the homes of relatives where health care can be provided as needed. The committee believes that a refundable income tax credit will help to overcome the difficulties many families now experience in providing home health care for elderly family members. The tax credit will assist families in paying for the costs of providing quality health care in the home.

The tax credit is directed towards low and middle-income taxpayers because the Committee believes that these taxpayers are in the greatest need of relief. This is accomplished by allowing a maximum credit of $500 for family incomes below $30,000 and phasing down the maximum credit above that level until it is eliminated at the $40,000 income level. The refundability feature will ensure that the credit will be available to families even if they have no income tax liability.

*Explanation of provision*

The committee's bill amends the Internal Revenue Code to allow a refundable credit against the income tax payable for the year to individuals who provide home health care for certain disabled qualified dependents who would otherwise require institutionalization.

The credit will be 50 percent of the amount spent by the taxpayer in supporting any qualified dependent that is in excess of any dependency tax exemption allowed to the taxpayer with respect to the qualified dependent. Under section 151(f) of the Internal Revenue Code the dependency exemption is currently $1,000; this exemption is allowed to the taxpayer for each dependent who either has a gross income of less than $1,000, is a child of the taxpayer and less than 19 years of age, or is a child of the taxpayer and a full time student. Under the bill the total credit, regardless of the number of qualified dependents, may not exceed $500. This amount is reduced by $50 for each $1,000 (or fraction thereof) by which the taxpayer's adjusted gross income exceeds $30,000. A taxpayer with an adjusted gross income of more than $39,000 will therefore be ineligible for the credit.

The credit applies to expenses paid by the taxpayer in supporting qualified dependents during the calendar year ending with or within the taxpayer's taxable year.

An individual must satisfy four requirements to be a qualified dependent. First, the individual must actually live in the home of the taxpayer for at least 270 days of the year. An individual will not be considered to live in the taxpayer's home for any day in which the individual is institutionalized. If, for any reason, the individual lives in the taxpayer's home for less than 270 days of the year, the individual will not be a qualified dependent. Second, the individual must be a dependent of the taxpayer, as defined by section 152 of the Internal Revenue Code. Under section 152 a dependent is an individual who receives over half of his support for the calendar year from the taxpayer, and who has one of several specified relationships of blood, marriage, or adoption to the taxpayer, or who actually lives in the taxpayer's home and is part of his household. Third, the individual must be determined to be afflicted by a medically determinable physical or mental impairment which can be expected to result in death or to be of a long-continued and indefinite duration. The Secretary of the Treasury is required to consult with the Secretary of Health and Human Services and to prescribe regulations for the purpose of making the necessary determination. Fourth, the individual must be physically or mentally impaired to the extent that institutionalization would be required if adequate care in the taxpayer's home was unavailable. The individual, therefore, must require health care or rehabilitory services of a sort that would require the individual to be confined in a hospital or skilled nursing facility if the care were not available in the home. An individual who merely receives medical services in the taxpayer's home that would customarily be provided on an outpatient basis by a hospital or skilled nursing facility would not be a qualified dependent.

To be eligible for the credit, the taxpayer must furnish more than 50 percent of the cost of maintaining a household in which a qualified dependent is a member. Amounts which are received from other individuals for the support of the qualified dependent but are treated as paid by the taxpayer under a multiple support agreement will also be treated as amounts furnished by the taxpayer to maintain the household.

The credit may be used to offset income tax liability for the taxable year; any unused portion of the credit will be refundable. Except as specifically provided, amounts spent to support qualified dependents will be eligible for this credit even if a credit or deduction for the same expenses is allowed elsewhere in the Internal Revenue Code.

### *Effective date*

The tax credit will apply to expenses incurred in taxable years beginning after December 31, 1982 and before January 1, 1985. To give Congress an opportunity to appraise the effect of this credit and to determine whether an extension beyond these two years would be in the public interest, the Secretary of the Treasury is required to prepare a report by September 30, 1982 estimating the credit's use and its effect on federal revenues.

## COST ESTIMATE

As America's population grows proportionately older the nation's demand for health care for the elderly will increase. It has been reported in this document (see Background and Committee Views Sections) that the great demand on health care facilities (i.e. hospitals and nursing homes) by the elderly patient will only increase as their population numbers increase. These demographic changes have strained the ability of the current health care system to adequately provide for the chronically ill elderly. This, combined with significant cost growth for institutional care (due to either inadequate targeting of services for the patient or inadequate alternative resources for patient care which in turn result in overutilization of increasingly more expensive types of care) has suggested the need for more effective and efficient alternatives. The Committee views this need to provide alternative systems of long-term care in a cost-effective manner as the basic tenet of this legislation.

An analysis of the cost-effectiveness of S. 234 should consider not only the initial cost that would occur with the enactment of this legislation but also the cost savings due to reducing institutional use and better targeting of services to those most in need. The Committee has reviewed a large number of programs that have conclusively demonstrated an ability of expanded home care services to reduce institutional use. For example, the Alternative Program (TAP) in the State of Utah developed partially in response to the state's increased nursing home costs addresses this issue. This project, in operation since 1978, has reduced the number of inappropriate and/or premature admissions of elderly persons to nursing homes and has maintained these clients outside the institution at a lower cost to the state then would have been the case if they had been admitted to nursing homes. Many other examples of home care providing an effective offset to institutional cost were discussed in the Background Section.

Generalizing these findings into overall cost estimates for S. 234 is, however, difficult. Several key variables, such as the initial utilization rate of the population and frequency of services must be based on rather rough estimates since reliable data on comparable experiences do not exist. It is for this reason that the Chairman of the Labor and Human Resources Committee requested the Congressional Budget Office to give special attention to certain factors and to present a range of estimates. It is also for this reason that the Committee has prepared an alternative estimate.

The Chairman requested the Congressional Budget Office to review the following when preparing cost estimates for S. 234:

1. *Demographics.*—To ascertain how current unmet needs were determined; what types of patients are considered as being treated in home care, nursing homes and hospitals and does this differ from the types of patients currently served in these settings?

2. *Offsets.*—Cost offsets that would occur due to decreases in institutional care or in the rate of growth in institutional care.

3. *Alternatives.*—Estimate the cost of meeting the increased demand for care of the elderly under the current law.

The full text of the Chairman's letter to the Congressional Budget Office follows:

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
*Washington, D.C., January 4, 1982.*

MS. ALICE RIVLIN,
*Director, Congressional Budget Office,*
*Washington, D.C.*

DEAR MS. RIVLIN: On December 15, 1981, the Senate Committee on Labor and Human Resources approved and ordered reported, S.

234, "The Community Home Health Services Act of 1981." As the Congressional Budget Office prepares cost estimates for this legislation we would like to ask that several areas be presented in more detail.

As you may know, it is the intention of this legislation to encourage and assist the elderly who are infirm or chronically ill to receive health care at home rather than in expensive institutions. The increased utilization of home health care should result in federal cost savings through decreased nursing home and hospital admissions as well as by increasing family support for the elderly. The exact levels of savings, costs and improved quality of life are hard to quantify and the net costs estimated by CBO are likely to be the subject to dispute. Therefore, we would like to request that CBO clearly delineate its assumptions in formulating an estimate of the costs associated with S. 234.

We would also like more detail on how CBO does or will estimate the affected population, for example: a. What types of patients are being considered for home, nursing home and hospital care? b. Does this differ from the types of patients currently served in these settings? c. Was family support for home care patients estimated? d. How was current unmet need determined?

As our nation will be facing a growing population of older citizens, the demands on its health care system will increase. Is home health care a less expensive option than that of building additional nursing homes or increasing the treatment of chronic patients in hospitals? Based on the demographics used to estimate S. 234, we would like CBO to estimate the cost of meeting this increased demand under the current system of care.

For each of the above areas we would like the assumptions used in the estimates to be clearly specified and sensitivity analyses run. Due to the amount of uncertainty in this area we would like, where appropriate, a range of estimates for costs. Considering that these changes will occur over a period of time, we would also like CBO to show how these changes occur over a number of years. As your work progresses and you are able to supply this Committee with preliminary figures we would like to review them and work as closely as possible with you to complete this work.

The Committee has a filing deadline of January 19th and anticipate the inclusion of your findings in that report. Thank you for your cooperation and assistance in this matter.

Sincerely,

ORRIN G. HATCH, *Chairman.*

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U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
*Washington, D.C., February 19, 1982.*

Hon. ORRIN G. HATCH,
*Chairman, Committee on Labor and Human Resources, U.S. Senate,*
*Washington, D.C.*

DEAR MR. CHAIRMAN: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for S. 234, the Community Home Health Services Act of 1981.

Should the Committee so desire, we would be pleased to provide further details on the atttached cost estimate.

Sincerely,

RAYMOND C. SCHEPPACH
(For Alice M. Rivlin, Director).

## CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: S. 234.
2. Bill title: The Community Home Health Services Act of 1981.
3. Bill status: As reported by the Committee on Labor and Human Resources on January 19, 1982.
4. Bill purpose: The bill would encourage the establishment of home health programs, expand the coverage of home health services under Medicare, and encourage individuals to provide care for qualified disabled dependents in the home of the individual.
5. Cost estimate:

[By fiscal years, in millions of dollars]

| | 1983 | 1984 | 1985 | 1986 | 1987 |
|---|---|---|---|---|---|
| Public Health Service Act (secs. 339(a) and (b)) (function 550): | | | | | |
| Authorization levels | 7.0 | 7.0 | | | |
| Outlays | 4.4 | 5.6 | 1.2 | −0.2 | −0.6 |
| Medicare (function 550): | | | | | |
| Budget authority | −78.0 | −371.0 | −676.0 | −990.0 | −1,314.0 |
| Outlays | 2,397.0 | 3,520.0 | 3,920.0 | 4,340.0 | 4,760.0 |
| Revenues [1] | | −300.0 | −300.0 | | |
| Net budget impact [2] | 2,401.4 | 3,825.6 | 4,221.2 | 4,339.8 | 4,759.4 |

[1] The revenue loss is the result of a refundable tax credit. A small portion of this revenue loss might be classified as an outlay, because some of the tax credits may not directly offset tax revenues.

[2] Net budget impact is estimated outlays plus revenue losses.

6. Basis for estimate: The following detailed cost analysis addresses only those sections of this bill that would have a budgetary impact.

### SECTION 3: HOME HEALTH SERVICES

Section 3 amends Title III of the Public Health Service Act. This section would encourage the establishment of home health programs by authorizing grants and loans to meet the initial costs of establishing and operating home health agencies. This section would also authorize grants and contracts for the training of professional and paraprofessional personnel who provide home health services.

[By fiscal years, in millions of dollars]

| | 1983 | 1984 | 1985 | 1986 | 1987 |
|---|---|---|---|---|---|
| Authorization Levels: | | | | | |
| Grants and loans for the initial cost of home health agencies (sec. 339 (a)) | 5.0 | 5.0 | | | |
| Grants and contracts for training (sec. 339 (b)) | 2.0 | 2.0 | | | |
| Outlays: | | | | | |
| Grants and loans for the initial cost of home health agencies (sec. 339 (a)) | 3.4 | 3.9 | 0.3 | −0.3 | −0.7 |
| Grants and contracts for training (sec. 339 (b)) | 1.0 | 1.7 | .9 | .3 | .1 |

The authorization levels for sections 339(a) and 339(b) are specified in the bill. Authorized amounts are assumed to be fully appropriated at the beginning of each fiscal year. For section 339(a), funds are assumed to be distributed equally between grants and loans. Outlays are estimated using spendout rates computed by CBO on the basis of appropriate recent program data. The loan amounts are assumed to be repaid on a schedule similar to other recent program loans.

### SECTION 4: MEDICARE AND MEDICAID PROVISIONS

This section of the bill would amend Title XVIII of the Social Security Act to expand the coverage of home health services under Medicare. Specifically, the bill would add respiratory therapy, occupational therapy and services of a homemaker-home health aid as qualifying services for home health care. Also, reimbursement would be provided for transportation in connection with any of the covered services. In addition to expanding covered benefits, this section would also increase the supply of providers to include organizations other than home health agencies.

[By fiscal years, in millions of dollars]

| | 1983 | 1984 | 1985 | 1986 | 1987 |
|---|---|---|---|---|---|
| Budget authority: Medicare | −78 | −371 | −676 | −990 | −1, 314 |
| Outlays: Medicare | 2, 397 | 3, 520 | 3, 920 | 4. 340 | 4, 760 |

Title XVIII of the Social Security Act currently provides home health care services to Medicare recipients. To be eligible for home health coverage under Medicare, a person must essentially be homebound, be under the care of a physician, and need skilled nursing care or physical or speech therapy. The care must be prescribed by a physician and the services must be provided by a participating home health agency.

The basic Medicare home health care services include part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse, physical or speech therapy, occupational therapy,[1] medical-social services, and part-time or intermittent services from a home health aide for help in activities of daily living such as bathing and dressing.

Home health benefits provided under either part A or B of Medicare are available to beneficiaries at no cost. The program also authorizes payments for medical supplies and appliances, excluding drugs and biologicals.

This bill would amend Title XVIII of the Social Security Act to expand existing coverage of home health care. Eligibility would be expanded so that enrollees could qualify for home health services if they were in need of homemaker-home health aide services on an intermittent basis or in need of occupational or respiratory therapy services. Medicare reimbursement for the homemaker-home health aide services would be limited to 50 percent of what would otherwise have been paid for Medicare services, but only for those recipients who qualified for home care solely on the basis of need for aid, occupational or respiratory care services. The new services provided by this bill include household care services such as food purchase and preparation, light housekeeping, and transportation in connection with other covered services.

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[1] The Omnibus Reconciliation Act of 1981 (P.L. 97-35) eliminated occupational therapy as an initial qualifying service, while maintaining it as a covered service.

In addition to changes in eligibility requirements and covered services, the bill would also expand the range of providers. The Secretary of HHS would be granted the authority, within certain guidelines, to waive the requirement that home health services must be provided by a home health agency.

The amendments made by this section would be effective 90 days after the date of the enactment of this act. CBO has assumed an enactment date of June 30, 1982.

The first year costs for this section do not reflect a full year impact of the Medicare provisions. Based on discussion with home health agency representatives, CBO assumes that all services could be fully operational within 4 to 6 months. CBO has therefore assumed a phase-in of the program over the first 6 months.

Using information from studies by the General Accounting Office and the Department of Health and Human Services, CBO estimates that first year costs for this section would be $2.4 billion. This estimate is based on the assumption that over 6 million people could qualify for homemaker-home health aide, occupational therapy, respiratory therapy, or transportation services. The service with the largest associated cost ($1.8 billion) is the provision allowing homemaker-home health aide care as an initially qualifying service. The estimate for homemaker-home health aide services assumes a 35 percent participation rate of the population at risk, with an average utilization rate of 60 visits per year. The average visit charge for 1983 is estimated at $33. The total costs for providing occupational therapy, respiratory therapy, and transportation services is $0.6 billion. The following discussion provides a detailed analysis of these major assumptions.

*Homemaker-home health aide services*

About 5 to 6 percent of the elderly population is institutionalized. Estimates of the noninstitutionalized elderly disabled population range from 20 to 40 percent, depending primarily on the degree and definitions of disability. Under current law, Medicare individuals must essentially be homebound to receive home health care benefits. The Medicare definition of homebound specifies that the condition of these patients should be such that there exists a normal inability to leave home and that leaving the home requires a considerable and taxable effort. However, the patient may still be considered homebound if absences from home are infrequent or for relatively short duration.

Based on a study by researchers at the Philadelphia Geriatric Center, CBO estimated that 25 percent of the noninstitutionalized elderly are essentially homebound and would therefore qualify for home care services under the provisions of this bill. Of this 25 percent, 8 to 10 percent are as functionally impaired as those in institutions. Another 10 percent are bed ridden or homebound. The remainder can leave the home, but with only a great deal of difficulty. Thus, applying this 25 percent to the approximately 26 million elderly people and 3 million disabled who will qualify for Medicare benefits in 1983, CBO estimates that over 6 million elderly and another 0.7 million disabled people could receive benefits under the provisions of this bill. In 1979, 300,000 individuals received home health aide service as an adjunct to skilled nursing care; thus, this bill would allow about 6.4 million additional people to qualify for homemaker-home health aide benefits.

In addition to the estimate of the eligible population, three other assumptions were necessary to estimate the costs of homemaker-home health aide services: 1) the charge per visit, 2) the average utilization rate for visits, and 3) the participation rate of the eligible population.

Based on information from the Health Care Financing Administration (HCFA), the average visit charge for home health aides in 1983 is estimated to be $33. This estimate was derived using a 1981 average visit charge of $29 which was then inflated using a special price index developed by HCFA for home care services.

CBO assumed a utilization rate of 60 visits per year and a participation rate of 35 percent. The utilization rate is based on data from the Title XX program. Under Title XX, grants are awarded to the states for the provision of services, including homemaker services. The Department of Health and Human Services estimated that homemaker services would be provided to about 368,000 individuals at a cost of $635 million in 1981 In 1981 the average visit charge under Medicare was $29, thus representing about 60 visits per year per recipient. However, Title XX home care services are not provided as an entitlement to qualifying recipients as are benefits under Medicare. Thus, this estimate does not reflect the individual recipient's perceived need for such services, which could be higher than the estimated utilization rate.

The participation rate is also a function of individual choice. CBO assumed that not all 6.4 million people would choose to seek homemaker-home health aide services, especially since there would be a 50 percent cost sharing for those not receiving other previously covered initially qualifying services. In the absence of relevant data, CBO assumed that 35 percent of this group might reasonably be expected to utilize these services.

Using these assumptions, CBO's estimate of the Medicare costs in fiscal year 1983 is $1.7 billion. However, both the average utilization rate and the participation rate were extremely difficult to estimate. The costs of homemaker-home health aide services are very sensitive to changes in both these rates. The chart below displays the potential Medicare costs for providing home health aide services under various alternative utilization rates and participation rates.

MEDICARE COSTS FOR HOME HEALTH AIDE SERVICES

[Fiscal year 1983, in billions of dollars]

| Utilization | Participation rate | | |
|---|---|---|---|
| | 25 percent | 35 percent | 45 percent |
| 30 per year | 0.5 | 0.8 | 1.1 |
| 60 per year | 1.1 | 1.7 | 2.2 |
| 120 per year | 2.0 | 3.3 | 4.3 |
| 180 per year | 3.1 | 5.0 | 6.5 |
| 240 per year | 4.1 | 6.7 | 8.4 |

This chart indicates that costs could increase or decrease depending on behavior. At a 35 percent participation rate, costs could range from $1 billion to as high as $7 billion in 1983, although utilization rates in the upper range are doubtful.

This bill would have other costs as well, including the costs for extending homemaker-home health aide services to those recipients currently receiving such services.

Based on information from HCFA, CBO estimates that the additional Medicare costs of expanding homemaker-home health services for current recipients of home care would be $170 million in 1983. HCFA has previously estimated that the cost for continuing to provide home health aide services to home care recipients once they no longer required skilled nursing care would be $600 million in 1983. This estimate of $600 million was reduced by CBO to reflect the 50 percent cost sharing, the correspondingly lower participation rate, and the phasing in the program.

CBO estimates that this bill would have no significant budgetary impact on Medicaid program expenditures, as there would be no requirement for states to provide reimbursement for a Medicare/Medicaid patient's 50 percent share of homemaker-home health aide services. CBO assumes that most states would not choose to increase their program costs. However, if States did choose to provide reimbursement for these services, the corresponding federal share could be over $200 million in 1983.

In addition to the costs of homemaker-home health aide services, CBO also examined potential offsetting savings for the hospitalized and institutionalized populations encouraged to leave hospitals and seek home care as a result of this provision. Extended home care services, such as aide services, may provide options for some people who would prefer to be treated at home. CBO assumed that these offsets would be $40 million in 1983. This estimate was based on several assumptions.

Some individuals will choose to leave institutions because of increased home care services. Based on previous CBO estimates, this study assumes that home care for these individuals would cost 55 percent of the cost of nursing care. If all of these emptied nursing home beds remained empty, savings would be achieved.

However, there is currently a long queue for nursing home beds, and it is very likely that any bed which is emptied will be filled by other patients. A PSRO one day census in 1980 counted 17,783 Medicare and Medicaid patients in hospitals who were waiting for institutional placement and about 10 percent of the noninstitutionalized population is as severely disabled as the institutionalized population (an estimated 2.5 million in 1983). Therefore, it is assumed that there would be no net decrease in the number of patients in nursing homes through 1987.

However, savings would be achieved to the extent that some of the people transferring to nursing home beds would be leaving hospitals. The issue becomes even more complex when the effects of the Omnibus Reconciliation Act of 1981 are considered. That law set reimbursement for patient back-up days at the average state Medicaid rate for skilled nursing facility care. A previous CBO estimate assumed that only 10 percent of hospital back-up days would be exempt from the Reconciliation bill. Under the provision of this bill, then, there would be no savings achieved by shifting patients from the hospital to the nursing home for 90 percent of hospital back-up days. Based on recent historical data, CBO assumed a hospital rate of $300 per day. If all of the patients backed up in hospitals were shifted to nursing homes and an equal number were shifted from nursing homes to the community, the total savings would be $75 million in 1983.

However, it is very unlikely that all of these savings would be achieved because of many factors. GAO noted in its 1979 study that Medicaid nursing home patients would have great difficulty in returning to the community because they have given up most of their savings and resources. In addition, there is another problem in calculating savings for the Medicare population. In the skilled nursing home, Medicare will pay the Medicare rate, while in the hospital as a back-up patient Medicare will pay the average state Medicaid rate for skilled nursing care. The Medicaid rate is on average $11 less per day than the Medicare rate. Thus, costs for these patients will increase as they shift from hospital back-up to a nursing home. Finally, for private pay patients, the extended benefits of home care may provide an incentive to return to the community and to begin to utilize Medicare home health benefits. While each of these factors is difficult to quantify, they will all decrease the savings from this offset. CBO has assumed that in 1983, about one-half of the savings would be achieved, or $40 million.

*Occupational therapy*

The cost of adding occupational therapy as an initially qualifying service for home care is estimated to be $27 million in 1983. This estimate is based on a previous CBO estimate.

The Omnibus Reconciliation Act of 1980 (P.L. 96–499) made occupational therapy an initially qualifying service for home health care. The following year, the Omnibus Reconciliation Act of 1981 (P.L. 97–35) eliminated occupational therapy as an initially qualifying service while maintaining it as a continuing qualfying service. Thus, although recipients could no longer qualify for home health care on the basis of need for occupational therapy, once they qualified for other services, they would be covered for occupational therapy. Occupational therapy could continue after the individual's initially qualifying service was terminated.

The provisions of this bill would once again establish occupational therapy as an initially qualifying service. Therefore, the costs for this provision are $27 million in 1983, which are equal to the savings estimated for removing these services under P.L. 97–35.

*Respiratory therapy*

The cost of adding respiratory therapy as an initially qualifying service for home care is estimated to be $280 million in 1983. Currently, respiratory therapy is not a covered home health service. This estimate is based on information from HCFA.

HCFA has previously estimated the costs of adding respiratory therapy as a qualifying service to be $340 million in 1983. Their estimate was based on the assumption that reimbursement would be limited to a maximum of $500 per beneficiary. In addition, HCFA's estimate also assumed that respiratory home services would be provided for all types of respiratory illnesses.

This bill does not include a limit on reimbursement per recipient. However, coverage is limited to those patients diagnosed with chronic obstructive pulmonary disease. Based on information from the National Institutes of Health, CBO estimates that 55 percent of the population with chronic respiratory illnesses is diagnosed with chronic obstructive pulmonary disease. CBO estimates that the costs for services would be approximately $1,000 per year. This is based on the costs of providing respiratory therapy services, some skilled nursing care for patients initially leaving hospitals, and necessary medical equipment, such as breathing equipment and oxygen to patients. Thus, total 1983 costs are estimated to be $280 million.

### *Transportation*

The costs for including Medicare coverage for transportation in connection with the covered services are estimated to be $260 million in 1983.

The estimate is based on data from the Title XX program. In 1978, about 5 percent of Title XX recipients per quarter received transportation services. The annual expenditure for these services was $62.9 million, or $190 per person. Allowing for inflation, in 1983 these same services would cost $330 per person.

The number of people who could reasonably be expected to utilize these transportation services under Medicare is difficult to estimate. Total recipients of home care are estimated here to be over 3.2 million in 1983 (2.2 million new home care recipients and about 1 million previously qualifying recipients). If 5 percent of the group utilized transportation services the cost would be $69 million in 1983. If everyone used the services the cost would be $1.4 billion in 1983.

CBO had little data on which to base an estimate of utilization of transportation services. We assumed, however, that transportation would be utilized more widely than under Title XX if it were provided as an entitlement at no cost to the individual. CBO also assumed that individuals who were severely disabled would need transportation and that one-fourth of this population was likely to use such services. The total costs in 1983 were estimated at $260 million.

### *Summary*

In summary, the total costs for the provisions of this section are estimated to be $2.4 billion in 1983. This estimate assumes that services will be phased in over the first six months of operation. Costs in the outyears were estimated using HCFA's projected growth rates for current home health services.

## SECTION 5: REFUNDABLE INCOME TAX CREDIT

Section 5 amends the Internal Revenue Code to provide a $500 refundable tax credit to taxpayers who provide home care to a qualified dependent. The credit would phase out when incomes grow from $30,000 to $40,000. This tax credit would be in effect for tax years 1983 and 1984 and would have a budgetary impact in the fiscal years as shown below.

**Revenues:**

| Fiscal year: | *Millions* |
|---|---|
| 1983 | −$300 |
| 1984 | −300 |
| 1985 | ------ |
| 1986 | ------ |
| 1987 | ------ |

To qualify for the proposed tax credit (1) the dependent must suffer from a physical or mental disorder of "long-continued and indefinite duration" which requires institutionalization; (2) the dependent must reside with the taxpayer for at least 270 days annually; and (3) the taxpayer must provide the majority of the individual's support during the year. Individuals with a physical impairment and those with chronic mental problems would potentially be eligible dependents for this credit.

About eight percent of the adult population is severely physically disabled, of which about 9 million are not in the labor force and thus must be supported. Only about one-quarter of this group, 2.5 million persons, receives the majority of its support from other family members. However, not all of these people live at home for 270 days. Based on recent discharge and average length of stay data for both hospitals and nursing homes, CBO estimates that between 0.3 and 0.6 million of these people will meet the 270 minimum days requirement.

In addition to the physically disabled eligibles, many chronically mentally disabled people might be considered dependents for this credit. At least half of the chronically mentally ill, about 2 million persons, are not continuously institutionalized, and 80 percent of all hospital patients treated for psychiatric disorders are discharged within 90 days. Conservative estimates for the period 1975–77 indicate that at least 0.7 million such individuals remain in the community most of the year, and about 0.2 million are hospitalized for less than 90 days. Of this total (0.9 million), fewer than 0.2 million return home to family.

While some people living in the community would become eligible dependents, it seems unlikely that disabled individuals would leave institutions because of this credit. In 1976, in 80 percent of all cases, relatives of an institutionalized person did not contribute at all to that person's care. A few families might be induced to alter their behavior and care for their dependent relative at home, although the reduction in their cost of home care of $1.50 per day, the approximate amount provided by a $500 tax credit, seems a small incentive.

The credit is reduced for qualifying taxpayers with income over $30,000. For every $1,000 over $30,000 the credit is reduced by $50. At an income of $40,000 there would no longer be a tax credit. In 1976, the median annual income of next-of-kin was $11,500. Of those reporting their income, about 4.5 percent of next-of-kin earned incomes above $25,000. Since 1976, personal income (on a national income accounts basis) has risen about 70 percent. A reasonable estimate of the proportion of next-of-kin with adjusted gross incomes in excess of $30,000 presently might be between 5 and 10 percent of all taxpayers. Most families would thus receive the full amount of the credit.

**Because the tax credit is refundable, individuals who do not pay tax could still be eligible for this credit. In such a case, the credit amount would appear as an outlay and not a revenue loss. CBO has assumed that these outlay amounts would be insignificant.**

**Conservatively, between 0.5 and 0.8 million individuals with severe disabilities would probably qualify under current guidelines for the proposed $500 tax credit and roughly 90 percent would receive the full amount of the credit. Thus the credit's annual cost in lost tax revenues would amount to between $200 and $400 million. CBO assumes a cost of $300 million. However, without stringent supervision by the IRS, a much larger segment of the disabled population would attempt to apply for the credit, potentially doubling or tripling the credit's cost.**

**7. Estimate comparison: None.**

**8. Previous CBO estimate: None.**

**9. Estimate prepared by: Hinda Ripps; revenue estimate prepared by: Hyman Sanders.**

**10. Estimate approved by:**

C. G. NUCKOLS,
(For James L. Blum,
*Assistant Director for Budget Analysis*).

## COMMITTEE COMMENTS

The committee commends CBO on a thoughtful and diligently prepared cost estimate of S. 234. However, both the assumptions employed and CBO's conclusions are subject to a lively and serious debate, suggesting that any single cost estimate is not in itself sufficient to accurately forecast either the total savings or costs of S. 234. For example, we wish to comment on CBO's choice of assumptions used in their baseline estimate. CBO's estimate is driven by three critical factors—the projected cost of a homemaker-home health aide visit, the visit frequency (utilization rate), and the population participation rate. The latter two factors deserve particular attention.

CBO's baseline estimate for homemaker-home health aide services assumes a utilization rate of 60 visits per year. This is predicated on homemaker service data taken from the Title XX program. However, this utilization rate may provide a high estimate since Title XX homemaker services are fully covered; that is, are not subject to a copayment provision, such as the 50 percent copayment provision of S. 234. This copayment provision should reduce the average number of visits per patient. In fact, that is exactly why this provision is included in the legislation. S. 234 attempts to provide a mechanism whereby those in need of services receive them, while supplying incentives for avoiding unnecessary use. In this case the copayment will provide an incentive for patients to take the initiative to care for themselves as soon as medically safe, rather than continuing very marginal or unnecessary care.

For these reasons we feel that the utilization rate should be estimated below the Title XX data of 60 visits per year. An estimate of 50 visits per year would be somewhat more realistic, and in fact, may even at this more plausible rate be too high. A second area needing to be addressed is the participation rate. CBO uses a 35 percent participation rate in its baseline figures. While the Committee hopes that as many as possible of the truly infirm elderly, use these services, we also believe that, realistically, this CBO projected participation rate is too high. CBO categorizes three groups of eligible individuals: (1) those who are as functionally impaired as individuals in institutions, (2) bedridden or homebound elderly, and (3) the remainder, who can leave the home, but with difficulty. CBO estimates that a full 32 to 40 percent of the eligibles fall into category one. These individuals, based on their levels of disability, would in all likelihood theoretically qualify for skilled care. However, few of these individuals avail themselves of the home health benefits provided under Part A and B of Medicare which is available to beneficiaries at no cost. It is unlikely that these people who generally do not avail themselves of a no cost medical option will partake heavily of a copayment service. Therefore, if we assume a 10 percent participation rate among individuals in this category and a 40 percent participation rate (higher than CBO's average of 35 percent) for the other two categories, we see an overall participation rate of approximately 30 percent.

Therefore, the Committee believes that a more realistic high estimate for the baseline figure for the average number of visits is 50 per year (compared to CBO's estimate of 60 visits) and that a more reasonable estimate of participation rate is 30 percent (compared with CBO's estimate of 35 percent). Using these two estimates the baseline estimate becomes $1.2 billion for homemaker-home health aide services (compared to CBO's estimate of $1.7 billion) and the total cost of the legislation becomes $1.9 billion in 1983. Projections for all other years would be similarly reduced. The Committee is also concerned about the proper treatment of the issue of cost offsets. CBO focuses the cost offsets on the number of infirm elderly who can be removed from nursing home care or hospital care and treated in their own homes due to the services provided by S. 234. They are correct in assuming that it is difficult to return the elderly to the community after any extended stay in institutions. When institutionalized the elderly often lose their ties to the community and their financial independence. However, we do not accept their assumption that the back log for nursing home care is so large that there would be no net decrease in the number of patients in nursing home beds through 1987.

Part of the queue of patients awaiting placement in nursing home beds is caused by the fact that alternatives to institutional care do not exist in some areas. S. 234 addresses the problem by promoting development of new home care agencies and by expanding the service coverage. As alternatives to institutional care become available individuals can receive less expensive care in their homes rather than entering institutions. These provisions address the important offset issue of preventing institutionalization in addition to savings from transferring from one formal care setting to another.

One qualifying factor for receipt of homemaker-home health aide services under S. 234 is a physician's certification that the elderly client would be institutionalized if it were not for these services. Therefore we are dealing with an institutional at-risk population. By CBO's estimate it would cost almost twice as much to care for the elderly in a nursing home as would be necessary to provide the services under S. 234 that would prevent or delay institutionalization of these patients. This delay or prevention of institutionalization is an important cost offset feature. If institutionalization is prevented or delayed for only 10 percent of the chronically ill elderly that CBO estimates will use homemaker-home health aide services under S. 234 approximately $200–400 million savings per year would be realized over the cost of having to care for these people in an institutional setting. The provision of the tax credit to families must also be considered when discussing cost offsets. To the extent the tax credit encourages families to provide for their elderly relatives at home rather than allowing them to enter an institution we will again evidence a delay or prevention of institutional care and again realize the associated cost savings. If only 10 percent of the elderly covered by the tax provision were to avoid institutionalization almost one third of the expenditures on this provision of the legislation would be offset.

The intent of S. 234 is not only to help elderly patients leave nursing homes and hospitals in order to receive chronic care in their home settings, but also to delay or prevent the infirm elderly from having to leave the community setting at all. CBO estimates that care in the community setting costs only 55 percent as much as institutional care. Therefore, to the extent that S. 234 can delay or prevent institutionalization, significant cost offsets can be realized. This is a situation where the government can, not only provide a more efficient and effective health care service, but also provide one that most of the elderly desire.

## CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standard Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

## PUBLIC HEALTH SERVICE ACT

* * * * * * *

## TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * * * *

### PART D—PRIMARY HEALTH CARE

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### Subpart III—Home Health Services

#### HOME HEALTH SERVICES

[SEC. 339. (a)(1) For the purpose of demonstration the establishment and initial operation of home health agencies (as defined in section 1861(o) of the Social Secrity Act) which will provide home health services (as defined in section 1861(m) of the Social Security Act) in areas in which such services are not otherwise available, the Secretary may, in accordance with the provisions of this section, make grants to public and nonprofit private entities to meet the initial costs of establishing and operating such agencies and expanding the services available through existing agencies, and to meet the costs of compensating professional and paraprofessional personnel during the initial operation of such agencies or the expansion of services of existing agencies. Demonstration projects and programs are to be conducted, to the extent practicable, in rural and urban areas, in sparsely and densely populated areas, and in areas with inadequate means of transportation.

[(2) In making grants under this subsection, the Secretary shall consider the relative needs of the several States for home health services and preference shall be given to areas within a State in which a high percentage of the population proposed to be served is composed of individuals who are elderly, medically indigent, or both.

[(3) Applications for grants under this subsection shall be in such form and contain such information as the Secretary shall by regulation prescribe.

[(4) Payments under grants under this subsection may be made in advance on the basis of estimates or by the way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of such grants.

[(5) There are authorized to be appropriated for grants under this subsection $14,000,000 for the fiscal year ending September 30, 1979, $16,100,000 for the fiscal year ending September 30, 1980, and $18,500,000 for the fiscal year ending September 30, 1981.

[(b) (1) The Secretary may make grants to and enter into contracts with public and nonprofit private entities to assist them in demonstrating the training of professional and paraprofessional personnel to provide home health services (as defined in section 1861(m) of the Social Security Act).

[(2) Applications for grants under this subsection shall be in such form and contain such information as the Secretary shall by regulation prescribe.

[(3) Payments under grants under this subsection may be made in advance on the basis of estimates or by the way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of such grants. The authority of the Secretary to enter into contracts under this subsection shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance by appropriations Acts.

[(4) There are authorized to be appropriated for grants under this subsection $1,500,000 for the fiscal year ending September 30, 1979, $2,000,000 for the fiscal year ending September 30, 1980, and $2,500,000 for the fiscal year ending September 30, 1981.]

*SEC. 339. (a) (1) For the purpose of encouraging the establishment and initial operation of home health programs to provide home health services (as defined in section 1861(m) of the Social Security Act) in areas in which such services are not otherwise available, the Secretary may, in accordance with the provisions of this section, make grants to public and nonprofit private entities and loans to proprietary entities to meet the initial costs of establishing and operating such home health programs. Such grants and loans may include funds to provide training to professional and paraprofessional personnel to provide home health services (as defined in section 1861(m) of the Social Security Act). The Secretary shall make grants and loans to entities for home health programs only in those areas which do not have adequate home health services, and shall give special consideration to areas with inadequate means of transportation to obtain necessary health services—*

*(2) In making grants and loans under this subsection, the Secretary shall—*

*(A) consider the relative needs of the several States for home health services; and*

*(B) give preference to areas in which a high percentage of the population proposed to be served is composed of individuals who are elderly, medically indigent, or disabled.*

*(3)(A) No loan may be made to a proprietary entity under this section unless the application of such entity for such loan contains assurances satisfactory to the Secretary that—*

*(i) at the time the application is made the entity is fiscally sound;*

*(ii) the entity is unable to secure a loan for the project for which the application is submitted from non-Federal lenders at the rate of interest prevailing in the area in which the entity is located; and*

*(iii) during the period of the loan, such entity will remain fiscally sound.*

*(B) Loans under this section shall be made at an interest rate comparable to the rate of interest prevailing on such date with respect to the marketable obligations of the United States of comparable maturities, adjusted to provide for administrative costs.*

*(4) Applications for grants and loans under this subsection shall be in such form and contain such information as the Secretary shall prescribe.*

*(5) Payments under grants and loans under this subsection may be made in advance on the basis of estimates or by way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of such grants and loans.*

*(6) There are authorized to be appropriated for grants and loans under this subsection $5,000,000 for each of the fiscal years ending September 30, 1984.*

*(b)(1) The Secretary may make grants to and enter into contracts with public and private entities to assist them in developing appropriate training programs for professional and paraprofessional personnel to provide home health services (as defined in section 8161(m) of the Social Security Act).*

*(2) In making grants and entering into contracts under this subsection, special consideration shall be given to entities which establish or will establish programs to provide training for persons fifty years of age and older who wish to become homemaker home health aides.*

*(3) Applications for grants and contracts under this subsection shall be in such form and contain such information as the Secretary shall prescribe.*

*(4) Payments under grants and contracts under this subsection may be made in advance on the basis of estimates or by way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of such grants and contracts.*

*(5) There are authorized to be appropriated for grants and contracts under this subsection $2,000,000 for each of the fiscal years ending September 30, 1983, and September 30, 1984.*

*(c) The Secretary shall report to the Committee on Labor and Human Resources of the Senate and the Committee on Energy and Commerce of the House of Representatives on or before January 1, 1984, with respect to—*

*(1) the impact of grants made and contracts entered into under subsections (a) and (b) (as such subsections were in effect prior to October 1, 1981);*

*(2) the need to continue grants and loans under subsections (a) and (b) (as such subsections are in effect on the day after the date of enactment of the Community Home Health Services Act of 1981);*

*(3) the extent to which standards have been applied to the training of personnel who provide home health services;*

*(4) the extent to which training costs for personnel who provide home health services are, or could be made, reimbursable under titles XVIII and XIX of the Social Security Act; and*

*(5) the efforts and progress of the Department in stemming any fraud and abuse with respect to home health services provided under this section and under titles XVIII and XIX of the Social Security Act.*

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# SOCIAL SECURITY ACT, AS AMENDED

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## TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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## PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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### Conditions of and Limitations on Payment for Services

#### REQUIREMENT OF REQUESTS AND CERTIFICATIONS

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition noncommunicable;

(C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

[(D) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical, occupational, or speech therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician;]

*(D) in the case of home health services—*

*(i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7));*

*(ii) such services are or were required because the individual needs or needed—*

*(I) skilled nursing care on an intermittent basis,*

*(II) physical or speech therapy, or*

*(III) homemaker-home health aide services on an intermittent basis (which are not otherwise available through family or community resources on a more cost-effective basis), or occupational or respiratory therapy; but only if such individual would require institutionalization in the absence of such homemaker-home health aide services, or occupational or respiratory therapy;*

*(iii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and*

*(iv) such services are or were furnished while the individual was under the care of a physician; or*

(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, require hospitalization in connection with the provision of such services; or

(F) in the case of alcohol detoxification facility services, such services are required on an inpatient basis (based upon an examination by such certifying physician made prior to initiation of alcohol detoxification);

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### AMOUNT PAID TO PROVIDERS

(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—

(1) **[**except as provided in paragraph (3),**]** *except as provided in paragraphs (3) and (4)* the lesser of (A) the reasonable cost of such services, as determined under section 1861(v) and as further limited by section 1881(b)(2)(B), or (B) the customary charges with respect to such services;

(2) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services; **[**or**]**

(3) if some or all of the hospitals in a State have been reimbursed for services (for which payment may be made under this part) pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972, if the rate of increase in such hospitals in their costs per hospital inpatient admission of individuals entitled to benefits under this part over the duration of such project was equal to or less than such rate of increase for admissions of such individuals with respect to all hospitals in the United States during such period, and if either the State has legislative authority to operate such system and the State elects to have reimbursement to such hospitals made in accordance with this paragraph or the system is operated through a voluntary agreement of hospitals and such hospitals elect to have reimbursement to those hospitals made in accordance with this paragraph, then the Secretary may provide for continuation of reimbursement to such hospitals under such system until the Secretary determines that—

(A) a third-party payor reimburses such a hospital on a basis other than under such system, or

(B) the rate of increase for the previous three-year period in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such [period.] *period; or*

*(4) 50 percent of the amount which would otherwise be paid under this part in the case of payment for the services of a homemaker-home health aide which constitute home health services provided to an individual who meets the requirements of subsection (a)(2)(D) only by reason of his need for the services of a homemaker-home health aide, occupational therapy, or respiratory therapy.*

In the case of any State which has had such a demonstration project reimbursement system in continuous operation since July 1, 1977, the Secretary shall provide under paragraph (3) for continuation of reimbursement to hospitals in the State under such system until the Secretary determines that either of the conditions described in subparagraph (A) or (B) of such paragraph has occurred.

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1832(b)(3)(ii) for all physicians' services furnished by him to hospital inpatients enrolled under this part, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant

to subsection (h) of this section), (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to expenses incurred for physicians' services (furnished by a physician who has an agreement in effect with the Secretary by which the physician agrees to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all physicians' services which are preadmission diagnostic services furnished by the physician to individuals enrolled under this part) which are preadmission diagnostic services for which payment may be made under this part and which are furnished (i) in the outpatient department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or, to the extent practicable as determined by regulations prescribed by the Secretary, to another hospital, or (ii) to the extent practicable as determined by regulations prescribed by the Secretary, in a physician's office within seven days of such individual's admission to a hospital as an inpatient, the amounts paid shall be equal to the reasonable charges for such services, (G) with respect to expenses incurred for services described in subsection (i)(3) under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services, and (H) with respect to items and services described in section 1861(s)(10), the amounts paid shall be 100 percent of the reasonable charges for such items and services, and

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), and (F) of such section and in paragraph (5) of this subsection and unless otherwise specified in section 1881)—

(A) with respect to home health [services] *services, except as otherwise provided in subparagraph (D) of this paragraph,* and to items and services described in section 1861(s)(10), the lesser of—

(i) the reasonable cost of such services, as determined under section 1861(v), or

(ii) the customary charges with respect to such services, or, if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);

(B) with respect to other services (except those described in subparagraph (C) of this paragraph)—

(i) the lesser of—

(I) the reasonable cost of such services, as determined under section 1861(v), or

(II) the customary charges with respect to such services,

less the amount of a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such reasonable cost, or

(ii) if such services are furnished by a public provider of services free of charge or at nominal charges to the the public, 80 percent of the amount determined in accordance with section 1814(b)(2), or

(iii) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section; [and]

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services; and

*(D) 50 percent of the amount which would otherwise be paid under this part in the case of the services of a homemaker-home health aide which constitute home health services provided to an individual who meets the requirements of section 1835(a)(2)(A) only by reason of his need for the services of a homemaker-home health aide, occupational therapy, or respiratory therapy.*

(3) in the case of services described in subparagraphs (D) and (E) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)) exceed 80 percent of such costs;

* * * * * * *

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

[(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical, occupational, or speech therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician ;]

(*A*) *in the case of home health services—*

(*i*) *such services are or were required because the individual is or was confined to his home* (*except when receiving items and services referred to in section 1861* (*m*) (*7*));

(*ii*) *such services are or were required because the individual needs or needed—*

(*I*) *skilled nursing care on an intermittent basis,*

(*II*) *physical or speech therapy, or*

(*III*) *homemaker-home health aide services on an intermittent basis* (*which are not otherwise available through family or community resources on a more cost-effective basis*), *or occupational or respiratory therapy; but only if such individual would require institutionalization in the absence of such homemaker-home health aide services, or occupational or respiratory therapy;*

(*iii*) *a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and*

(*iv*) *such services are or were furnished while the individual was under the care of a physician;*

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## PART C—MISCELLANEOUS PROVISIONS

### Definition of Services, Institutions, etc.

SEC. 1861. For purposes of this title—

#### SPELL OF ILLNESS

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#### HOME HEALTH SERVICES

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech [therapy;] *therapy, or, with respect to services related to the treatment of chronic obstructive pulmonary disease, respiratory therapy;*

(3) medical social services under the direction of a physician;

[(4) to the extent permitted in regulations, part-time or inter-

**mittent services of a home health aide who has successfully completed a training program approved by the Secretary;]**

(*4*) *to the extent permitted by regulations, services of a part-time or intermittent homemaker-home health aide—*

(*A*) *who—*

(*i*) *has successfully completed a training program which extends for at least 40 hours, and consists of classroom instruction and at least 20 hours* (*in the aggregate*) *of supervised clinical instruction, and which is directed toward preparing students to deliver home health services; or*

(*ii*) *has demonstrated, pursuant to regulations promulgated by the Secretary, an equivalent amount of training by work experience, or through testing, licensure, or other means;*

(*B*) *which are carried out under appropriate professional supervision and are designed to maintain or enhance the personal care of an individual in his home* (*but not including any structural changes to the home*) *in a manner which promotes the functional independence of the individual; and*

(*C*) *which include—*

(*i*) *personal care services designed to assist such individual in the activities of daily living such as bathing, exercising, personal grooming, and getting in and out of bed; and*

(*ii*) *household care services such as maintaining a safe living environment, light housekeeping, and ensuring good nutrition* (*including the purchase and preparation of food*)*;*

(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A), [but not including transportation of the individual in connection with any such item or service;] *including transportation of the individual in connection with any such item or service if such item or service cannot be provided within the home in a more cost-effective manner* (*as determined by the Secretary in regulations*)*;*

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

*The Secretary may by regulation waive the requirement that home health services must be provided by a home health agency when such services can be provided by an entity which demonstrates that it can substantially comply with the provisions of subsection (o), but only if the Secretary determines that such entity provides such services in a manner which assures the quality of, and the effective and efficient delivery of, such services.*

* * * * * * *

(v)(1)(L)(i) * * *

(ii) The Secretary, in determining the amount of the payments that may be made under this title with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) the 75th percentile of such costs per visit for home health agencies, or, in the judgment of the Secretary, such lower percentile or such comparable or lower limit (based on or related to the mean of the costs of such agencies or otherwise) as the Secretary may determine. *Such limitations shall not vary between hospital-based home health agencies and freestanding home health agencies.* The Secretary may provide for such exemptions and exceptions to such limitation as he deems appropriate.

## TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

### STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

* * * * * * *

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1864(a)), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, **[and]**

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) or paragraphs (11) and

(12) of section 1861(s), or, in the case of a laboratory which is in a rural health clinic, of section [1861(aa)(2)(G):] *1861(aa)(2)(G), and*

*(D) that any homemaker-home health aide services paid for under the plan must be provided by a homemaker-home health aide who meets the requirements of section 1861(m)(4)(A) of this Act;*

* * * * * * *

## INTERNAL REVENUE CODE OF 1954, AS AMENDED

* * * * * * *

### SEC. 44C. RESIDENTIAL ENERGY CREDIT.

(a) General Rule.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the sum of—

(1) the qualified energy conservation expenditures, plus

(2) the qualified renewable energy source expenditures.

(b) Qualified Expenditures.—For purposes of subsection (a)—

(1) Energy conservation.—In the case of any dwelling unit, the qualified energy conservation expenditures are 15 percent of so much of the energy conservation expenditures made by the taxpayer during the taxable year with respect to such unit as does not exceed $2,000.

(2) Renewable energy source.—In the case of any dwelling unit, the qualified renewable energy source expenditures are 40 percent of so much of the renewable energy source expenditures made by the taxpayer during the taxable year with respect to such unit as does not exceed $10,000.

(3) Prior expenditures by taxpayer on same residence taken into account.—If for any prior year a credit was allowed to the taxpayer under this section with respect to any dwelling unit by reason of energy conservation expenditures or renewable energy source expenditures, paragraph (1) or (2) (whichever is appropriate) shall be applied for the taxable year with respect to such dwelling unit by reducing each dollar amount contained in such paragraph by the prior year expenditures taken into account under such paragraph.

(4) Minimum dollar amount.—No credit shall be allowed under this section with respect to any return for any taxable year if the amount which would (but for this paragraph) be allowed with respect to such return is less than $10.

(5) Application with other credits.—The credit allowed by subsection (a) shall not exceed the tax imposed by this chapter for the taxable year, reduced by the sum of the credits allowable under a section of this subpart having a lower number or letter designation than this section, other than credits allowable by sections 31, 39, [and 43] *43, and 44H.*

* * * * * * *

### SEC. 44D. CREDIT FOR PRODUCING FUEL FROM A NONCONVENTIONAL SOURCE.

(a) Allowance of Credit.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to—

(1) $3, multiplied by

(2) the barrel-of-oil equivalent of qualified fuels—

(A) sold by the taxpayer to an unrelated person during the taxable year, and

(B) the production of which is attributable to the taxpayer.

(b) Limitations and Adjustments.—

(1) Phaseout of credit.—The amount of the credit allowable under subsection (a) shall be reduced by an amount which bears the same ratio to the amount of the credit (determined without regard to this paragraph) as—

(A) the amount by which the reference price for the calendar year in which the taxable year begins exceeds $23.50, bears to

(B) $6.

(2) Credit and phaseout adjustment based on inflation.—The $3 amount in subsection (a) and the $23.50 and $6 amounts in paragraph (1) shall each be adjusted by multiplying such amount by the inflation adjustment factor for the calendar year in which a taxable year begins. In the case of gas from a tight formation, the $3 amount in subsection (a) shall not be adjusted.

(3) Credit reduced for grants, tax-exempt bonds, and subsidized energy financing.—

(A) In general.—The amount of the credit allowable under subsection (a) with respect to any project for any taxable year (determined after the application of paragraphs (1) and (2)) shall be reduced by the amount which is the product of the amount so determined for such year and a fraction—

(i) the numerator of which is the sum, for the taxable year and all prior taxable years, of—

(I) grants provided by the United States, a State, or a political subdivision of a State for use in connection with the project.

(II) proceeds of any issue of State or local government obligations used to provide financing for the project the interest on which is exempt from tax under section 103, and

(II) the aggregate amount of subsidized energy financing (within the meaning of section 48(l)(11)

(C) provided in connection with the project, and

(ii) the denominator of which is the aggregate amount of additions to the capital account for the project for the taxable year and all prior taxable years.

(B) Amounts determined at close of year.—The amounts under subparagraph (A) for any taxable year shall be determined as of the close of the taxable year.

(4) Credit reduced for energy credit.—The amount allowable as a credit under subsection (a) with respect to any project for any taxable year (determined after the application of paragraphs (1), (2), and (3)) shall be reduced by the excess of—

(A) the aggregate amount allowed under section 38 for the taxable year or any prior taxable year by reason of the energy percentage with respect to property used in the project, over

(B) the aggregate amount recaptured with respect to the amount described in subparagraph (A)—

(i) under section 47 for the taxable year or any prior taxable year, or

(ii) under this paragraph for any prior taxable year.

The amount recaptured under section 47 with respect to any property shall be appropriately reduced to take into account any reduction in the credit allowed by this section by reason of the preceding sentence.

(5) Application with other credits.—The credit allowed by subsection (a) for a taxable year shall not exceed the tax imposed by this chapter for such taxable year, reduced by the sum of the credits allowable under a section of this subpart having a lower number or letter designation than this section, other than the credits allowable by sections 31, 39, [and 43.] *43, and 44H.* For purposes of the preceding sentence, the term "tax imposed by this chapter" shall not include any tax treated as not imposed by this chapter under the last sentence of section 53(a).

* * * * * * *

### SEC. 44E. ALCOHOL USED AS FUEL.

(a)-(d) * * *

(e) Limitation Based on Amount of Tax.—

(1) In general.—The amount of the credit allowed by this section for the taxable year shall not exceed the tax imposed by this chapter for the taxable year, reduced by the sum of the credits allowed under a section of this subpart having a lower number designation than this section, other than credits allowable by sections 31, 39, [and 43.] *43, and 44H.* For purposes of the preceding sentence, the term "tax imposed by this chapter" shall not include any tax treated as not imposed by this chapter under the last sentence of section 53(a).

* * * * * * *

### *SEC. 44H. HOUSEHOLDS WITH CERTAIN DISABLED DEPENDENTS.*

*(a) In general.—In the case of an eligible individual, there shall be allowed a credit against the tax imposed by this chapter for the taxable year an amount equal to 50 percent of the excess, if any, of—*

*(1) the expenses paid by such eligible individual in supporting any qualified dependent of such eligible individual during the calendar year ending with or within such taxable year, over*

*(2) the amount of any exemption allowed such eligible individual under section 151 with respect to such qualified dependent for such taxable year.*

*(b) Limitation.—The amount of credit allowable to any taxpayer under subsection (a) for any taxable year shall not exceed an amount equal to—*

*(1) $500, reduced (but not below zero) by*

*(2) $50 for each $,1000, or fraction thereof, of that portion of such taxpayer's adjusted gross income for such taxable year which is in excess of $30,000.*

*(c) Definitions special rules.—For purposes of this section—*

*(1) Eligible individual.—The term "eligible individual" means an individual who, for the calendar year ending with or within the taxable year, maintains as his home a household of which a qualified dependent of such individual for such calendar year is a member.*

*(2) Qualified dependent.—The term "qualified dependent" means, with respect to an eligible individual for the calendar year, any individual—*

*(A) whose place of abode for at least 270 days of such calendar year is the home of such eligible individual.*

*(B) who is a dependent of such eligible individual (within the meaning of section 152) for such calendar year,*

*(C) who, under regulations prescribed by the Secretary after consultation with the Secretary of Health and Human Services, is determined to be afflicted by a medically determinable physical or mental impairment which can be expected to result in death or to be of a long-continued and indefinite duration, and*

*(D) who would require institutionalization if adequate care at the home of such eligible individual was unavailable.*

*(3) Maintenance of a household.—*

*(A) In general.—An individual shall be treated as maintaining a household for a calendar year only if more than 50 percent of the cost of maintaining such household for such calendar year is furnished by such individual.*

*(B) Multiple support agreements.—For purposes of subparagraph (A), any support of a qualified individual treated as received from an individual under section 152(c) for such calendar year shall be treated as a cost of maintaining such household furnished by such individual for such calendar year.*

### SEC. 55. ALTERNATIVE MINIMUM TAX FOR TAXPAYERS OTHER THAN CORPORATIONS.

(a) * * *

(b) Definitions.—For purposes of this section—

(1) Alternative minimum taxable income.—The term "alternative minimum taxable income" means gross income—

(A) reduced by the sum of the deductions allowed for the taxable year,

(B) reduced by the sum of any amounts included in income under section 86 or 667, and

(C) increased by an amount equal to the sum of the tax preference items for—

(i) adjusted itemized deductions (within the meaning of section 57(a)(1)), and

(ii) capital gains (within the meaning of section 57(a)(9)).

For purposes of subparagraph (A), a deduction shall not be taken into account to the extent such deduction may be carried to another taxable year.

(2) Regular tax.—The term "regular tax" means the taxes imposed by this chapter for the taxable year (computed without regard to this section and without regard to the taxes imposed by sections 72(m)(5)(B), 402(e), 408(f), 409(c), and 667(b)) reduced by the sum of the credits allowable under subpart A of part IV of this subchapter (other than under sections 31, [39 and 43).] *39, 43, and 44H)*. For purposes of this paragraph, the amount of the credits allowable under such subpart shall be determined without regard to this section.

*  *  *  *  *  *  *

**SEC. 56. IMPOSITION OF TAX.**

(a) * * *

(b) * * *

(c) Regular Tax Deduction Defined.—For purposes of this section, the term "regular tax deduction" means an amount equal to one-half of (or in the case of a corporation, an amount equal to) the taxes imposed by this chapter for the taxable year (computed without regard to this part and without regard to the taxes imposed by sections 72(m)(5)(B), 402(e), 408(f), 531, and 541), reduced by the sum of the credits allowable under subpart A of part IV other than sections 31, 39, [and 43.] *43, and 44H.* For purposes of the preceding sentence, the amount of the credit allowable under section 38 shall be determined without regard to the employee plan percentage set forth in section 46(a)(2)(E).

*  *  *  *  *  *  *

**SEC. 6401. AMOUNTS TREATED AS OVERPAYMENTS.**

(a) Assessment and Collection After Limitation Period.—The term "overpayment" includes that part of the amount of the payment of any internal revenue tax which is assessed or collected after the expiration of the period of limitation properly applicable thereto.

(b) Excessive Credits.—If the amount allowable as credits under sections 31 (relating to tax withheld on wages) [and 39], *39* (relating to certain uses of gasoline, special fuels, and lubricating oil), [and 43 (relating to earned income credit).] *43 (relating to earned income credit), and 44H (relating to households with certain disabled dependents)*, exceeds the tax imposed by subtitle A (reduced by the credits allowable under subpart A of part IV of subchapter A of chapter 1, other than the credits allowable under sections 31, [39 and 43),] *39, 43, and 44H)*, the amount of such excess shall be considered an overpayment. For purposes of the preceding sentence, any credit allowed under paragraph (1) of section 32 (relating to withholding of tax on nonresident aliens and on foreign corporations) to a nonresident alien individual for a taxable year with respect to which an election under section 6013(g) or (h) is in effect shall be treated as an amount allowable as a credit under section 31.

*  *  *  *  *  *  *

## Regulatory Impact Statement

Pursuant to Section 602 of Senate Resolution 4 concerning the regulatory impact of proposed legislation, the Committee provides the following evaluation of the anticipated additional paperwork and other regulatory impact that would result from the implementation of S. 234. Section 3 of S. 234 revises and extends home health care programs under Title III, Part D, Subpart III of the Public Health Service Act, Sec. 4 of S. 234 amends and revises Sections 1814, 1833, 1835, 1861 and 1902 of the Social Security Act and amends the Internal Revenue Code to include a new Section 44H, a refundable income tax credit for households with certain disabled dependents.

## PUBLIC HEALTH SERVICE ACT

### *A. Estimated number of individuals or businesses regulated by group or class*

A new classification of individuals and businesses in the private sector could become subject to regulations regarding loans as a result of the Public Health Service Title III revisions. There are approximately 874 proprietary hospitals, of which 37 have home health units and 78 are under arrangements and 342 free-standing proprietary home health agencies would become eligible to apply for these loans. The Secretary may make loans to proprietary home health agencies who successfully comply with the criteria outlined in Section 3 of S. 234. Entities which receive such loans would be subject to certain regulations which pertain only to the loans.

### *B. Economic impact of such regulation on individuals or businesses*

There exists some cost involved with compiling of information and filing of application for loans by proprietary agencies. However, the Committee believes these modest costs will be recovered by the agency after initial start-up loans are paid.

### *C. Additional paperwork, time and cost*

Some additional paperwork, time and cost may be associated with the preparation and filing of applications for loans and grants. Information concerning for and content of such applications will appear in the Federal Register. S. 234 requires the Department of Health and Human Services to prepare reports regarding the impact of and need to continue these grants and loans; the extent to which standards for training of personnel who provide home health services have been applied and the extent to which training costs for these personnel could be reimbursed under titles XVIII and XIX of the Social Security Act. The Department is also required to report on its efforts to stem fraud and abuse of home health services under those same titles.

## SOCIAL SECURITY ACT

In implementing the various provisions of Section 4 of S. 234 there will be some increase in Federal regulatory activity; but enactment of S. 234 is not expected to cause a heavy or unusual regulatory burden. Some provisions may in fact, decrease regulatory activity and associated paperwork.

Section 4 of the bill amends various sections of the Social Security Act and will create the most regulatory change.

Inclusion of the definition of homemaker/home health aide in the

Social Security Act will decrease time and paperwork needed to reach final cost settlements between intermediaries and providers. The rate differentials will change for these services requiring some program cost, but it should decrease or be recovered with the completion of studies on, and the implementation of, the most cost-effective reimbursement methodologies.

Revised regulations will be necessary for reimbursement for transportation for an individual in connection with any such item or service of such item or service cannot be provided within the home.

Finally, a regulation will be implemented, allowing the Secretary to waive certification requirements for home health services in cases where the entity complies with criteria set forth in this Act. (See Committee Views)

### INTERNAL REVENUE CODE

The Treasury may be required to determine, for the purposes of the refundable tax credit, a "qualified dependent."

## Section-by-Section Analysis of S. 234

### SHORT TITLE

Provides that this Act may be cited as the "Community Home Health Services Act of 1981".

### PURPOSE

Section 2 declares that the purpose of this Act is to encourage the establishment of home health programs, to expand the coverage of home health services for the elderly and disabled under Medicare and Medicaid, and to encouragee individuals to provide care in their homes for certain qualified disabled dependents.

### GRANTS AND CONTRACTS FOR HOME HEALTH SERVICES AND TRAINING

Section 3 amends part D of title III of the Public Health Service Act to insert after subpart II a new subpart III—Home Health Services.

### HOME HEALTH SERVICES

New Section 339(a)(1) authorizes the Secretary of Health and Human Services to make grants to public and nonprofit private entities and loans to proprietary entities to meet the initial costs of establishing and operating home health programs to provide home health services (as defined under Medicare) in areas where such services are not otherwise available. Provides that such grants and loans may include funds for training professional and paraprofessional personnel to provide home health services (as defined under Medicare). Directs the Secretary to make such grants and loans only for programs in areas without adequate home health services, and to give special consideration to areas with inadequate means of transportation to obtain necessary health services.

New Section 339(a)(2) directs the Secretary, in making such grants and loans, to consider the relative needs of the several States for home health services and to give preference to areas with a high percentage of the elderly, medically indigent, or disabled.

New Section 339(a)(3)(A) provides that no loans be made to a proprietary entity unless such entity assures the Secretary that (1) at the time its loan application is made, the entity is fiscally sound, (2) the entity is unable to secure such a loan from non-Federal lenders at the rate of interest prevailing in the area in which the entity is located, and (3) during the period of the loan, such entity will remain fiscally sound.

New Section 339(a)(3)(B) provides that loans under this section will be made at an interest rate comparable to the rate of interest prevailing on such date with respect to the marketable obligations of the United States of comparable maturities, adjusted to provide for administrative costs.

New Section 339(a)(4) provides that applications for grants and loans under this subsection be made in such form and contain such information as the Secretary prescribes.

New Section 339(a)(5) permits payments under such grants and loans to be made in advance on the basis of estimates or by way of reimbursement, with adjustments for underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary.

New Section 339(a)(6) authorizes $5 million to be appropriated for grants and loans under this subsection for each of the fiscal years ending Sept. 30, 1983, and Sept. 30, 1984.

New Section 339(b)(1) authorizes the Secretary to make grants and enter into contracts with public and private entities for developing training programs for professional and paraprofessional personnel to provide home health services (as defined under Medicare).

New Section 339(b)(2) provides that, in making grants and entering into contracts under this subsection, special consideration be given to programs for training persons 50 years of age and older, to become homemaker-home health aides.

New Section 339(b)(3) provides that applications for such grants and contracts be in such form and contain such information as the Secretary prescribes.

New Section 339(b)(4) permits payments under such grants and contracts to be made in advance on the basis of estimates or by way of reimbursement, with adjustments for underpayment or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary.

New Section 339(b)(5) authorizes $2 million to be appropriated for grants and contracts for each of the fiscal years ending Sept. 30, 1983, and Sept. 30, 1984.

New Section 339(c) requires the Secretary to report to the Senate Committee on Labor and Human Resources and the House Committee on Energy and Commerce by Jan. 1, 1984, regarding the following:

(1) the impact of grants and contracts under subsections (a) and (b) (as such subsections were in effect prior to Oct. 1, 1981);

(2) the need to continue grants and loans under subsections (a)

and (b) (as such subsections are in effect on the day after the date of enactment of the Community Home Health Services Act of 1981);

(3) the extent to which standards have been applied to the training of personnel who provide home health services;

(4) the extent to which training costs for personnel who provide home health services are, or could be made, reimbursable under Medicare and Medicaid; and

(5) the efforts and progress of the Department in stemming any fraud and abuse in home health services provided under this section and under Medicare and Medicaid.

### MEDICARE AND MEDICAID PROVISIONS

Section 4(a)(1) amends section 1814(a)(2)(D) of the Social Security Act, pertaining to conditions of and limitations on payment for home health services under Medicare, to provide that:

(1) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7), pertaining to certain items and services furnished on an outpatient basis);

(2) such services are or were required because the individual needs or needed skilled nursing care on an intermittent basis; physical or speech therapy; or homemaker-home health aide services on an intermittent basis (not otherwise available through family or community resources on a more cost-effective basis), or occupational or respiratory therapy, but only if such individual would require institutionalization in the absence of such homemaker-home health aide services or occupational or respiratory therapy;

(3) a plan for furnishing such services has been established and is periodically reviewed by a physician; and

(4) such services are or were furnished while the individual was under the care of a physician.

Section 4(a)(2) amends section 1835(a)(2)(A) of such Act, pertaining to procedures for payment of claims by providers of home health services, to provide that:

(1) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7));

(2) such services are or were required because the individual needs or needed skilled nursing care on an intermittent basis; physical or speech therapy; or homemaker-home health aide services on an intermittent basis (not otherwise available through family or community resources on a more cost-effective basis), or occupational or respiratory therapy. but only if such individual would otherwise require institutionalization in the absence of such homemaker-home health aide services or occupational respiratory therapy;

(3) a plan for furnishing such services has been established and is periodically reviewed by a physician; and

(4) such services are or were furnished while the individual was under the care of a physician.

Section 4(b)(1) amends section 1861(m)(2) of such Act, to add after "speech therapy" the following: ", or, with respect to services related to the treatment of chronic obstructive pulmonary disease, respiratory therapy".

Section 4(b)(2) amends section 1861(m)(4) of such Act, to read as follows:

"(4) to the extent permitted by regulations, services of a part-time or intermittent homemaker-home health aide—

> (A) who has successfully completed a training program of at least 40 hours, consisting of classroom instruction and at least 20 hours (in the aggregate) of supervised clinical instruction, and which is directed toward preparing students to deliver home health services; or who has demonstrated, pursuant to regulations, an equivalent amount of training by work experience, or through testing, licensure, or other means;
>
> (B) which are carried out under appropriate professional supervision and are designed to maintain or enhance the personal care of an individual in his home (but not including any structural changes to the home) in a manner which promotes the functional independence of the individual; and
>
> (C) which include personal care services designed to assist such individual in the activities of daily living such as bathing, exercising, personal grooming, and getting in and out of bed; and household care services such as maintaining a safe living environment, light housekeeping, and ensuring good nutrition (including the purchase and preparation of food);".

Section 4(b)(3) amends section 1861(m)(7)(B), to strike out "but not including transportation of the individual in connection with any such item or services" and to insert in lieu thereof "including transportation of the individual in connection with any such item or service if such item or service cannot be provided within the home in a more cost-effective manner (as determined in regulations)".

Section 4(b)(4) amends section 1861(m), to add at the end thereof a new unnumbered paragraph, permitting the Secretary to waive by regulation the requirement that home health services must be provided by a home health agency when such services can be provided by an entity which demonstrates that it can substantially comply with the provisions of subsection (b) pertaining to the definition of a home health agency for purposes of Medicare. Permits this waiver only if the Secretary determines that such entity provides such services in a manner which assures the quality of, and the effective and efficient delivery of, such services.

Section 4(c)(1)(A)-(C) amends section 1814(b) of such Act to make various technical and conforming amendments.

Section 4(c)(1)(D) amends section 1814(b) of such Act to insert after paragraph (3) and before the last sentence of subsection (b) a new paragraph (4) providing that the amount paid to providers of home health services under Part A of Medicare will be 50 percent of the amount which would otherwise be paid for the services of a homemaker-home health aide which constitute home health services provided to an individual who meets the requirements of subsection (a)(2)(D) only by reason of his need for the services of a homemaker-home health aide, occupational therapy, or respiratory therapy.

Section 4(c)(2)(A)–(C) amends section 1833(a)(2) to make various technical and conforming amendments.

Section 4(c)(2)(D) amends section 1833(a)(2) to add after subparagraph (C) a new subparagraph (D) providing that payment of benefits for home health services under Part B of Medicare will be 50 percent of the amount which would otherwise be paid for the services of a homemaker-home health aide which constitute home health services provided to an individual who meets the requirements of section 1835(a)(2)(A) only by reason of his need for the services of a homemaker-home health aide, or occupational or respiratory therapy.

Section 4(d) amends section 1861(v)(1)(L)(ii) of such Act, pertaining to limits on reimbursement to home health agencies, to provide that such limitations will not vary between hospital-based home health agencies and free-standing home health agencies.

Section 4(e) amends section 1902(a)(9) of such Act to make various technical and conforming amendments and also to add at the end thereof a new subparagraph (D) providing that any homemaker-home health aide services paid for under a State Medicaid plan must be provided by a homemaker-home health aide meeting the newly imposed requirements of section 1861(m)(4)(A), pertaining to training or other qualifications.

Section 4(f) directs the Secretary of Health and Human Services to compile and analyze the results of any significant public or private studies relating to current and alternative reimbursement methodologies for home health services. Directs the Secretary to make recommendations regarding the possible application of such reimbursement methodologies to health care programs funded in whole or in part by Federal funds. Requires the Secretary to report such recommendations to Congress within 180 days after the date of enactment of this Act.

Section 4(g) requires the Secretary, within 180 days after the date of enactment of this Act, to implement, within the scope of his authority under section 1861(v) of the Social Security Act, pertaining to the definition of reasonable costs under Medicare, and with respect to the new services provided under this Act, those reimbursement methodologies determined to be the most cost-effective.

Section 4(h) requires the Secretary to develop and carry out demonstration projects commencing no later than Jan. 1, 1983, to test alternative reimbursement methodologies for home health agencies in order to determine the most cost-effective and efficient way of providing home health services under Medicare and Medicaid. Provides that reimbursement methodologies to be tested may include but are not limited to fee schedules, prospective reimbursement, and capitation payments. Requires the Secretary to report to Congress his findings with regard to these demonstrations no later than Jan. 1, 1984.

Section 4(i) requires the Secretary to undertake a thorough investigation of the methods available to stem fraud and abuse in the Medicare and Medicaid home health programs and the extent to which such methods are applied. Requires the Secretary to report the results of the investigation to Congress within 18 months after the date of enactment of this Act.

Section 4(j) provides that the amendments made by this section will become effective 90 days after the date of enactment of this Act and will be effective only with respect to items and services furnished on or after such effective date.

### REFUNDABLE INCOME TAX CREDIT

Section 5(a) amends subpart A of part IV of subchapter A of Chapter 1 of the Internal Revenue Code of 1954 (relating to credits allowable) to insert after section 44G a new section 44H, pertaining to tax credits for households with certain disabled dependents.

New Section 44H(a) provides that, in the case of an eligible individual, there will be allowed a tax credit for the taxable year in an amount equal to 50 percent of the excess (if any) of the expenses paid by such eligible individual in supporting any qualified dependent during the calendar year, over the amount of any exemption allowed such eligible individual under section 151 with respect to such qualified dependent for such taxable year.

New Section 44H(c)e(1) provides that, for purposes of this section, any taxpayer under subsection (a) for any taxable year will not exceed an amount equal to $500, reduced (but not below zero) by $50 for each $1,000, or fraction thereof, of that portion of such taxpayer's adjusted gross income for such taxable year which is in excess of $30,000.

New Secetion 44H(c)(1) provides that, for purposes of this section, the term "eligible individual" means an individual who, for the calendar year ending with or within the taxable year, maintains as his home a household of which a qualified dependent of such individual for such calendar year is a member.

New Section 44H(c)(2) provides that the term "qualified dependent" means, with respect to an eligible individual for the calendar year, any individual (A) whose place of abode for at least 270 days of such calendar year is the home of such eligible individual, (B) who is a dependent of such eligible individual (within the meaning of section 152) for calendar year, (C) who, under regulations prescribed by the Secretary of the Treasury after consulting with the Secretary of Health and Human Services, is determined to be afflicted by a medically determinable physical or mental impairment which can be expected to result in death or to be of a long-continued and indefinite duration, and (D) who would require institutionalization if adequate care at the home of such eligible individual was unavailable.

New Section 44H(c)(3) provides that an individual will be treated as maintaining a household for a calendar year only if more than 50 percent of the cost of maintaining such household for such calendar year is furnished by such individual. Further provides that any support of a qualified individual treated as received from an individual under section 152(c) for calendar year will be treated as a cost of maintaining such household furnished by such individual for such calendar year.

Section 5(b)(1) amends section 6401(b) of such Code (relating to excessive credits treated as overpayments) to make various technical and conforming amendments.

Section 5(c) amends the table of section for subpart A of part IV of subchapter A of chapter 1 of such Code to insert after the item relating to section 44G the following new item: "Sec. 44H. Households with certain disabled dependents."

Section 5(d) provides that the amendments made by this section will apply to taxable years beginning after Dec. 31, 1982, and before Jan. 1, 1985.

Section 5(e)(1) directs the Secretary of the Treasury to prepare a report estimating the number of individuals allowed the tax credit for households with certain disabled dependents for taxable years beginning in 1983, and the total effect on the revenues of the United States of allowing such credits.

Section 5(e)(2) requires that the report required under paragraph (1) be submitted to Congress no later than Sept. 30, 1984.

## Votes in Committee

Pursuant to Section 133(b) of the Legislative Reorganization Act of 1946, the following is a tabulation of votes cast in Committee on S. 234.

The bill, "Community Home Health Services Act of 1981", was considered in open executive session on December 15, 1981.

Senator Hatch offered an amended version of S. 234 which was accepted by a voice vote.

Senator Metzenbaum moved an amendment to establish a Federal annuity program to compensate participants in private pension plans which terminated before July 1, 1974, for nonforfeitable pension benefits which were lost by reason of the terminations. The amendment was withdrawn pending a request for a Government Accounting Office study of the issue.

Senator Hatch moved S. 234, as amended be reported to the Senate. The motion carried by a vote of 15 to one as follows:

### YEAS

Senator Hatch
Senator Stafford
Senator Quayle
Senator Hawkins
Senator Weicker
Senator Humphrey
Senator Denton
Senator East
Senator Kennedy
Senator Randolph
Senator Williams
Senator Pell
Senator Eagleton
Senator Riegle
Senator Metzenbaum

### NAYS

Senator Nickles

# ADDITIONAL VIEWS OF SENATOR DON NICKLES

Although I appreciate the Chairman's efforts and motivation behind S. 234, I must register by opposition to reporting out this bill at the present time.

S. 234 is a proposal to expand home health care services covered under Medicare and Medicaid. It is attractive because it seeks to assist the elderly and disabled in staying in their own homes or with family, rather than in an institution. Proponents maintain that care in the home will result in less cost to taxpayers, but they don't have all the facts before them, partly because all of the facts on home health care are not available.

## MEDICARE AND MEDICAID—OVERALL CONDITION OF ENTITLEMENT PROGRAMS

Before turning to specific consideration of S. 234, it is important to have an understanding of the solubility and inflationary problems of Medicare and Medicaid.

The Department of Health and Human Services is predicting a 14.3 percent increase in the cost of Medicare from 1981 to 1982. In dollars, that means a jump from about 42 billion to 47 billion, within one year. Should things continue as they have since the inception of Medicare, Trustees of the Medicare Trust Fund expect that the Fund will be completely bankrupt by the year of 1990.

The statistics surrounding Medicaid are not any more reassuring. The costs of Medicaid have jumped more than 12-fold in the 15-year life of the program, from 2.4 billion in 1967 to an estimated 30.5 billion in 1981. The cost increase has far exceeded the overall inflation rate, increasing more than 15 percent per year on average for the past five years. The federal share of the 30.5 billion is 17.1 billion.

With such a stage set on these seemingly uncontrollable entitlements and the difficulties that all of Congress anticipates in re-gaining some control, I think that any proposal to expand them should be analyzed with great care. Even a concept as attractive as home health care is to be subject to scrutiny for cost-effectiveness, for in the end, no one will benefit from new services if the system goes bankrupt and all services are endangered.

The second area which demands attention is the cost and cost-effectiveness of S. 234. If, in the long run, S. 234 promised to save money, then it would be a sound investment. But, it is in this area that the facts have not been complete or consistent.

## NO COST ESTIMATES AVAILABLE ON S. 234

At the time of the mark-up of S. 234, there were no estimates as to the cost of expanding Medicare and Medicaid with additional home health services. This makes it impossible to evaluate the total cost-effectiveness of the bill.

### GAO-NONCOMMITTAL ON POSSIBLE SAVINGS OF S. 234

In November of last year, the General Accounting Office presented testimony before the Labor and Human Resources Committee about the effects of expanding coverage for home health care under Medicaid and Medicare.

In their summary, they made the following points regarding the expected cost-effectiveness of S. 234:

1. Home care can reduce the hospital length of stay.
2. The effects of home care on the number of hospital admission/readmission rates are inconclusive.
3. The effects of home care on reducing the number of days that a person waits in the hospital for placement in a chronic care setting is unknown.
4. There is little or no evidence to suggest any savings in reduced placement in nursing homes.

GAO concluded by saying that, "The total effect of expanding home health care services on health costs is not known and it may never be known."

### SENATE GOVERNMENTAL AFFAIRS COMMITTEE—HOME HEALTH CARE OPEN TO FRAUD AND ABUSE

In October of 1981, the Permanent Subcommittee on Investigations under the Governmental Affairs Committee investigated the current home health care services which are provided under Medicare. Their conclusion was that the "Medicare home health care program is highly vulnerable to fraud, waste, and abuse, providing an almost open-ended opportunity for unscrupulous operators to profit substantially at the expense of the taxpayer."

### CURRENT HOME HEALTH SERVICES—COSTS ARE SOARING

In addition to the potential for abuse, home health care as it is already provided for under Medicare has increased in cost by 300 percent since 1976. S. 234 would add more areas for reimbursement, driving this increase up at an even faster rate.

### CONCLUSION

We have a serious problem in providing health care for an ever increasing elderly population. It is serious now, but it will explode in the next twenty years.

It may well be that home health care is one of the bright lights of the future. I hope so. But, to proceed in that direction without all of the facts before us is premature. Worse yet, it is to repeat the mistakes of the past.

I believe that some of the inflationary aspects of Medicare and Medicaid need to be restructured. To do that, we need some breathing time. A temporary halt in any expansions of the programs would be both prudent and wise.

In the interim, more research and evaluation of the home health care option needs to be done.

I encourage my colleagues to examine this bill closely, noting the cost and inconclusive testimony concerning any savings it will achieve.

Let's pursue the home health care concept, but let's not be premature in establishing public policy.

DON NICKLES.

# ADDITIONAL VIEWS OF SENATOR EDWARD M. KENNEDY

The Community Home Health Service Act of 1982 is an important first step in our nation's responsibility to meet the critical needs of the elderly and the disabled in America. By expanding the availability of home health services in a manner carefully targetted to help these individuals avoid unnecessary and costly institutionalization, the bill provides a humane, cost-effective approach to the growing concerns of providing appropriate services for our aging and disabled population. By supporting and encouraging family and community involvement, the bill helps strengthen the most important elements in assuring the quality of care.

An important feature of this legislation is its direction to the Secretary to examine and implement innovative reimbursement approaches to home health services. Unless we are able to curb the runaway cost of health care, the elderly will face the grim prospect of spending more and more of their limited dollars for less and less care.

Study after study has demonstrated what has long been apparent to the elderly, the disabled and their families—community and home based care can prolong life and enhance the dignity and independence of millions of our most valued citizens. I am encouraged that the Committee has begun the vital task of assuring that the elderly and disabled will have an opportunity to receive the assistance they need to live productive and fulfilling lives.

EDWARD M. KENNEDY.

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